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ABSTRACT

Little is known about urban American Indian elders, although most American Indians live off reservations in the nation's cities. Accordingly, this research project compiled information about these older Americans from the following databases: (1) results of academic and applied research; (2) Management Information System (MIS) reports of service providers in selected urban areas with significant American Indian populations; (3) surveys of selected urban American Indian organizations; and (4) results or data from federally funded demonstration projects which have targeted or incidentally served this population. The project produced a comprehensive research database which includes three topical bibliographies; demographic data; and documented needs for support services, availability and access to support services, and sociocultural factors which influence service delivery and use. The final report also identifies research gaps and recommends a national research agenda on aging among urban American Indians. This report also recommends policy and practices to increase access and availability of support services to older urban American Indians. (Author/TE)

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STUDY OF URBAN AMERICAN INDIAN AGING

FINAL REPORT: RESEARCH GRANT #ARO118

Presented to
Administration on Aging
Department of Health and Human Services
Washington, D.C. 20201

June 30, 1990

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STUDY OF URBAN AMERICAN INDIAN AGING

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II. A NOTE ON LANGUAGE

The term American Indian is used throughout the text in deference to the wishes of the elders on the Los Angeles American Indian Council on Aging, Inc. and the wishes expressed by the elders participating in the American Association of Retired Persons, Minority Affairs Initiative, 1988.

The term elder is used with reference to older American Indians. This is the term in common usage in American Indian communities and it carries a positive connotation.

III. PROJECT ABSTRACT

STUDY OF URBAN AMERICAN INDIAN AGING

Little is known about urban American Indian elders although most America Indians live off reservations in our nation's cities. This research project compiled the sparse but valuable information about these older Americans from the following data bases: 1) result of academic and applied research, 2) Management Information System (MIS) reports of service providers in selected urban areas with significant American Indian populations, 3) surveys of selected urban American Indian organizations, and 4) results or data from federally funded demonstration projects which have targeted or incidentally served this population.

The project produced a comprehensive research data base which includes three topical bibliographies, demographic data, documented needs for support services, availability and access to support services and sociocultural factors which impact on service delivery and utilization.

The final report also identified research gaps and recommended a national research agenda on urban American Indian aging. This report also recommends policy and practices to increase access and availability of support services to older urban American Indians.

IV. EXECUTIVE SUMMARY

A. PROJECT SUMMARY

The Problem

Little is known about urban American Indian aging. Most of the attention on American Indian aging issues has been focused on reservations where less than half of the total American Indian population lives. For decades urban American Indian organizations have reported that their population was aging in place in the nation's largest cities.

Objectives

The project's objectives were to compile and synthesize research on urban American Indian aging and to determine the patterns of support service utilization by urban American Indian elders. The databases compiled included: 1) results of academic and applied research, 2) Management Information System (MIS) data of service providers in selected urban areas with significant urban American Indian populations, 3) surveys of selected urban American Indian organizations and 4) results or data from federally funded demonstration projects which have targeted or incidentally served this population. The outcome of this project is a comprehensive research data base.

Unique Features of This Project

Most academic literature and policy analyses focus on older American Indians living on reservations. This project is unique in its emphasis on the urban population of older American Indians.

This project compiled data from diverse sources including demonstration and research projects, academic literature, Management Information System reports. In addition, original research was conducted on services available through urban American Indian organizations. The data base compiled in this report represents the first such work on urban American Indian Aging.

The project outcomes recommend new directions in understanding the needs and filling the gaps in service to this population. The proposed research agenda addresses issues which have not yet received attention through basic or applied research. The neglect of this population is identified in issues of policy analysis.

Results

An annotated bibliography focusing exclusively on urban American Indian aging was produced. The bibliography lists 97 reference sources. An additional 53 sources are listed in two separate bibliographies on Urbanization and on American Indian Aging.

Gaps and trends in research were identified. The growth in both number of reference sources and range of topics reflects the aging in place of urban American Indians over the last 30 years.

Specific research questions which remain unanswered were compiled into seventy-five areas of inquiry. Nine lines of inquiry were identified for the Aging Process In General, eight for Supportive Services and Senior Citizens Programs, seven for Program and Policy Issues, five for Long Term Care, 12 for Health, eight for Mental Health, 13 for Sociocultural Factors, 10 for Biomedical Factors, and four for Demography.

A success model for delivering service to urban American Indian elders was identified in the coordination of local Area Agencies on Aging and local urban multipurpose American Indian organizations. This model did not account for all the variation in service delivery noted on MIS reports. American Indians living in poverty and the percentage of the American Indian population served is reported for 18 Planning and Service Areas. In half of the Planning and Service Areas, services provided to American elders was not proportional to the percentage of the population living in poverty.

Implications

This project has important program and policy implications. A national research agenda is proposed with specific unanswered questions compiled from analysis of the literature. This agenda will be a useful guide to funding agencies and to scholars.

The bibliography is unique and will be widely used by scholars. It is the only source of materials which focuses exclusively on urban American Indian aging.

The findings on utilization suggest guidelines for local aging networks to follow in order to enhance access and availability of services to older American Indians. Policy concerns relating to this population have been identified. Resource allocation based on an economy of scale often fails to provide services to those in greatest social and economic need of a small minority population.

B. SUMMARY OF MAJOR FINDINGS

1. In nine of the eighteen metropolitan Planning and Service Areas surveyed, participation in Title III services by American Indians was below the proportion of that population living in poverty.

2. Nationwide the Management Information System (MIS) reporting for Title III(b) services funded by the Older Americans act is inconsistent and duplicative in contrast to MIS reporting for Title III(c) services.

3. The post-retirement residence choice of most urban American Indians is to remain in the cities where they have lived and been employed throughout their adult years. The commitment to stay in an urban area increases with age.

4. Urban Indian Centers are significant community nodes which attract a dispersed clientele in sufficient numbers to provide culturally sensitive programs in contract to most other "generic" site providers. Nevertheless, the majority of elders are generally served at the many generic meal sites located throughout any Planning and Service Area.

5. Those urban American Indian organizations which contract for Title III service provide twice the range of services to elders than American Indian organizations with generic services only.

6. Half of the urban American Indian centers offer congregate meal services and less than one-third provide home delivered meals. Health services and care management are available at 22.2% of the centers. Housekeeping/Home-making and Personal care are available at 27.8% of the centers. As a major community node for a population which is widely dispersed in urban areas, these represents critical gaps in services.

7. The number of sources and range of topics on urban American Indian aging has increased eighteen fold since 1960. The growth in the literature reflects the aging in place of this population in which the majority of persons relocated to cities during the period from 1950 - 1970.

8. The most frequently studied topics in the period from 1980 - 1990 were Health, Policy, Social Role and Support Service Delivery. None of these topics received any attention in 1960-1969.

9. Professional journals carry 33% of the literature on urban American Indian aging. In comparison to other literature on minority aging, urban American Indian aging is under-represented in professional proceedings and presentations. Much of the literature on urban American Indian aging is from difficult to obtain sources such as project reports and monographs of local organizations.

10. The existing literature on urban American Indian aging contains such disparate information that it is somewhat limited for developing comparative analyses.

11. The majority of literature on American Indian aging refers to reservation populations.

12. The early adult experience of the contemporary elder cohort has been documented in studies on urbanization and relocation. Unfortunately, the literature on urbanization of American Indians tends to focus on problems encountered rather than on the successes. Therefore, little is known about productive older American Indians who have aged in place in cities.

C. POLICY/PROGRAM IMPLICATIONS

Policy related to Title III Services

Participation by American Indian elders in Title III services was below the proportion of that population living in poverty in nine of eighteen metropolitan Planning and Service Areas with the largest concentrations of urban Americans. Policy which targets service to this small ethnic minority based on their percentage of the total aged population fails to serve American Indians in greatest social and economic need.

Future research agenda

A national research agenda is recommended by this project. The research questions are intended to suggest a program of inquiry which will define the unique social, cultural, psychological and physiological factors of urban American Indian Aging. The agenda proposes pursuit of questions in the areas of programs and policies which suggest best practice models. Seventy-five productive lines of inquiry are recommended.

Gaps in access and availability to Title III support services

Utilization patterns for support services received from Title III providers were compared with services received through urban multipurpose American Indian organizations. Gaps in services are often filled when American Indian organizations are Title III service contractors. Participation by urban American Indian organizations in the local aging networks increases the range of services available to elders and enhances access.

The success of American Indians peer outreach and linkage projects should be replicated and enhanced through training programs for American Indian professionals and paraprofessionals.

The dispersion of American Indian elders throughout urban areas is reflected in MIS data which reports that most nutrition sites provide service to one or two elders. Some providers, including the Indian centers, serve 30-50 elders. Providing culturally sensitive programs to relatively few participants is a challenge to the aging network. One solution long tested by the urban Indian centers is providing transportation for all on-site activities and services.

Identification of Research Gaps

This project produced the first annotated bibliography on urban American Indian aging. The project documents the current state of knowledge and trends in the study aging among urban American Indians for the last 30 years. The 18 fold growth in topics related to urban American Indian aging reflects the aging in place of that population. The most frequently addressed issues in the decade 1980 - 1990 are health, policy, social role, and delivery of support services. Applied and basic research on this population should continue to grow as the population of older urban American Indians increase.

Despite the growth in interest, the literature is sparse and not yet sufficient to develop rigorous comparative analyses.

Agenda for Professional Organizations

The majority of the literature appears in professional journals but, in comparison to literature on minority aging, is under-represented in presentations and proceedings of professional meetings.

D. RECOMMENDATIONS

1. Review and reevaluate policies which target services to American Indians to the extent of their percentage in the total population 60+ in a Planning and Service Area, but fail to target service to the majority of American Indians who are in greatest social and economic need.

2. Develop policies and encourage practices which effectively target services to older urban American Indians in greatest social and economic need.

3. Conduct research based on the proposed research agenda in the areas of aging, support services and programs, policy, health, mental health, biomedicine, sociocultural factors, demography and long term care.

4. Make available funding to conduct research and coordinate funding with other government agencies to support research on urban American Indian aging.

5. Enhance coordination between Area Agencies on Aging and urban American Indian multipurpose organizations to improve access to Title III services and to ensure that comprehensive community based long-term care is available to older American Indians.

6. Train American Indians in professional and paraprofessional positions to provide health, supportive services and long-term care to older American Indians. Every effort should be made to include older peer group members in training programs based on their success in outreach and linkage activities of Administration on Aging funded demonstration projects.

E. DISSEMINATION AND UTILIZATION

Final Report

This final report will be disseminated to over 120 agencies and professionals. The audience for the report includes:

- Government agencies concerned with aging, health, mental health and/or American Indians
- National American Indian organizations
- National aging network organizations
- National resource centers
- Major libraries and data bases
- Professionals conducting research or practicing in the field of minority aging
- American Indian organizations and aging network agencies which participated in this project's surveys

Press releases to professional newsletters in the fields of gerontology and anthropology will inform others of the project and its major findings.

Presentations

Presentations on this project were presented at the American Society on Aging annual meetings in 1989 and 1990 and at the Gerontological Society of America annual meetings in 1989. Findings will also be presented at the Summer Series on Aging sponsored by the American Society on Aging, 1990. Additional presentations at future annual meetings are planned.

Publications

Publications are anticipated in various journals and newsletters including The Gerontologist, Generations, Current Anthropology, Practicing Anthropology, Aging Connection, Newsletter of the Society for Anthropologists and Sociologists in Aging, and Aging.

V. INTRODUCTION

Older American Indians have been dubbed "The Forgotten People" both by American Indian advocates and by Congressional committees. Their oversight studies have concentrated on reservations where a special relationship exists between the federal government and the tribes. However, older American Indians who live in urban areas continue to be overlooked.

Little is known about the older urban American Indian although the major rural to urban migration of American Indians occurred in this century. Those who migrated to cities following World War II are now at retirement age and yet there is scant attention to this population in the literature.

Elders are a rapidly increasing segment of the American Indian population. The American Indian population over age 65 is predicted to double by the year 2000. Currently slightly more than half of the American Indian population lives in urban areas and slightly less than half of the elders are located in urban environments. Surveys of American Indian elders indicate that few elders intend returning to reservations after retirement and the numbers of urban American Indian elders will increase.

This report summarizes the state of knowledge about urban American Indian elderly and presents three topical annotated bibliographies. The bibliographic annotations include citations to literature with a single passing reference, as well as to research that focuses exclusively on urban American Indian elderly. To the extent possible, the annotation includes major findings and supporting data.

The existing literature on urban American Indian elders consists largely of ground-breaking research. Future research is recommended to clarify or confirm preliminary reports and to extend a limited data base. The recommendations are organized into a research agenda with 75 productive lines of inquiry suggested.

This report also examines access and availability of Title III supportive services to American Indian elders. Management Information System (MIS) data is analyzed for eighteen target cities having major American Indian populations. A survey of American Indian organizations in those key cities and the specific services offered to elders is also presented. Differential utilization and access rates are discussed and recommendations made.

VI. PROFILE OF CONTEMPORARY URBAN AMERICAN INDIAN ELDERS: OVERVIEW OF LITERATURE

The Gap in Knowledge on Urban America Indian Aging

The urban American Indian elder remains one of the least known of older American ethnic minorities (Block, 1979; Edwards, 1983). The limited state of knowledge is particularly shocking since the 1980 U.S. Census determined that the majority of American Indians live in the nation's cities and towns. Over the last two decades urban American Indian organizations have indicated the need to develop services for elders in their communities. The adult experiences of contemporary urban elders was documented particularly during the 1960's and 1970's focusing on their relocation to cities from reservations. Documentation of the rural-urban migwtion diminished after the federally assisted relocation programs ended. Virtually no attention has been given to aging in place.

Most academic research on urban American Indians examined the adjustment of individuals under the age of 25 or 30 years (Martin, 1964) to urban lifestyles and the affects of post-war federal relocation programs (Thornton, Sandefeur, Grasmick, 1982). Such research on urban American Indians focused on rural-urban migration (Neils 1971; Sorkin;1978), adaptive patterns (Ablon, 1964; Graves, 1970; Graves & Van Arsdale, 1966; Guillemin, 1975; Price, 1968) and social problems such as alcoholism (Burns, Daily, Moskowitz, 1974; Weibel & Weisner, 1980) and negative aspects of family life (Ryan, 1981). While studies on alcoholism continued through the 1980's, few researchers focused on the demographic and social trends of this population as its members approached retirement age. Block's (1979) prediction that the numbers of elderly living in cities would increase as assimilation progressed was left untested.

Early research indicated that American Indians did not necessarily consider the urban lifestyle as a permanent commitment (Guillemin, 1975; Neils, 1971; Sorkin, 1978). Cities were resource sites which they exploited while vigorous and reservations remained their "home base." The rate of return for early relocatees was as high as 75% and eventually was stabilized at 35% (Ablon, 1965). The lack of Indian Health Service medical care in cities was a powerful inducement for older American Indians to return to their natal reservations (Sorkin, 1978).

Urban American Indian organizations, however, reported that their populations had aged in place (Los Angeles City/County Native American Indian Commission, 1982; Montana United Indian Association, 1974). In-depth needs assessments were conducted by or in conjunction with Indian organizations for 144 elders in Phoenix (Eck & St. Louis, 1972), for 328 elders in Los Angeles (Weibel-Orlando & Kramer, 1989), for 28 elders in San Diego (Dukepoo, 1980) and for 524 elders in Denver (Tyon, 1990). In a recent survey, few urban elders (19%) intended to return to the reservations of their birth (Weibel-Orlando & Kramer, 1989). In Los Angeles, one-third of the elders were not enrolled in their respective tribes although the majority of elders were half or full blood American Indians (Weibel-Orlando & Kramer, 1989). Lacking tribal enrollment, it is unlikely that these individuals would migrate to reservations. The number of persons who are not enrolled, and therefore unlikely to consider migration, will increase as the contemporary elders' children and grandchildren age.

Contemporary American Indian elders choose to remain in the cities where they had established roots. The reservation is idealized as a possible retirement location even as social contacts and visits actually decline (Price, 1981). Those elders who have lived and worked in cities would need reorientation and retirement planning to readjust to life on a reservation (Curley, 1978).

The notion that American Indians retire and return "home" has remained current despite census evidence to the contrary. Dramatic press releases that most American Indian elders leave cities for natal reservations have been reprinted in popular (Citron, 1988; Hackett, Reese, Harlam, 1988), professional (Aging Services News, 1985) and American Indian presses (Lakota Times, 1985; Talking Leaf, 1985; Rifkin, 1989). Unfortunately, journalists did not analyze the total sample size of 28 persons for the research cited (Weibel-Orlando, 1988) in these press releases. Erroneous beliefs that no elders live in cities significantly reduced the response of the aging network in conducting applied research and planning for their needs (Briggs, 1987).

Block's (1979) prediction that American Indians would remain and age in cities has occurred. The proportion of that population aged 60+ will increase because the majority of the American Indian population already lives off-reservations. Furthermore, if urban American Indians are not enrolled tribal members, they may not be eligible for benefits on their tribe's reservation.

Factors Stimulating the Urban Migration of American Indians

Nearly all contemporary urban American Indian elders were born on reservations. The period of their youth, from 1920 to 1950, was an era of poverty on reservations. There were few opportunities for employment, malnutrition was common and education was limited. Cities provided economic opportunities which attracted American Indians from rural reservations. From 1900 to 1940 the percentage of American Indians living in urban areas increased from 0.4% to 7.0%. according to U.S. Censuses (Neils, 1971). By 1980 more than half the American Indian populated was located off-reservation.

The defense industry attracted many American Indians to industrial centers. During World War II, 22% of the entire American Indian population of 334,000 persons was employed in the military or in war industries for which they relocated permanently or temporarily (Neils, 1971). Following the war, in response to drought conditions in the southwest, the Labor Recruitment Welfare program was established to relocate Navajo and Hopi to Los Angeles, Denver, Phoenix and Salt Lake City.

The Eisenhower era policy toward American Indians was to terminate the special relationship between the federal government and tribal entities. The policy had earlier been recommended by the 1947 Hoover Commission as a recommendation to reduce government costs, inefficiency and duplication of services. Termination abrogated the unique and special relationship between the federal government and tribal entities. This trust relationship recognizes American Indian societies as self-governing "domestic dependent nations" and the federal government as having fiduciary responsibilities for land title and social services. Compliance with the termination policy was effected by withholding tribal funds, withholding loans to individual American Indians and disallowing tribal governments to review the specific statutes of terminations which would affect their people. The conversion of tribal assets to per capita payments was an incentive which was particularly well received among voting tribal members who had previously relocated to urban areas. Between 1954 and 1962, a series of Congressional resolutions removed federal services and protection from 61 tribes, groups, bands, communities and rancherias (Gibson, 1980; US Commission on Civil Rights, 1981).

Relocation of American Indians off reservations was integrated into the termination policy. The Voluntary Relocation Program, later renamed the Employment Assistance Program, was better known in the American Indian community as the "relocation program." Operated through the Bureau of Indian Affairs, the programs provided transportation, financial assistance, training and counseling. Offices were established in ten key cities to assist

American Indians in relocating to training or employment opportunities in metropolitan areas. Between 1952 and 1968 over 100,000 American Indians participated in these programs (Sorkin, 1969). With government assistance, the percentage of American Indians residing in cities increased dramatically.

During the post war period, west coast cities experienced rapid economic growth. The favorable climate and the expanding labor market attracted American Indians nationwide. This migration accounts for the great heterogeneity of tribes represented in Los Angeles in comparison to the relatively homogeneous population of Minneapolis. In general, the relocation centers located in heavily industrialized areas offered higher wages than other cities. Economic opportunities throughout the 1960's attracted both urban and rural American Indians to cities such as Seattle, Los Angeles and San Francisco rather than to the cities which had well-established American Indian populations such as New York City and Buffalo (Neils, 1971; Sorkin, 1972).

The massive relocation of American Indians from small-scale indigenous communities to large-scale industrial centers exacerbated social problems for a portion of that population. Studies of individual adjustment, alcoholism, drop-out rates and criminal behaviors were numerous (cf. Thornton, Sandefeur & Grasmick, 1982) and focused on these problems. Although it was seldom addressed in the literature, such social deviation was not universal among urban American Indians. Price (1968) also noted that there was a substantial difference between those American Indians who had been relocated and those who chose to live in Southern California on their own initiatives. The relocated population tended to be younger, have lower incomes, live proximally, associate more often with other American Indians, and were more likely to return to reservations if jobs were available there.

Opportunities for education and job advancement did indeed exist in metropolitan areas. In the twenty years, 1949 to 1969, urban male American Indian income increased at three times the rate of other minorities to equal the black male median income in 1969. Although concentrated in lower paying positions, the urban American Indian occupational status (1940-1970) was more favorable than blacks. More American Indians than blacks were classified as professionals, managers and craftsmen and fewer as operatives, laborers and service workers. Approximately 11% of both white and American Indian labor forces was technical and professional. Unlike reservations, schools existed in cities and the average educational attainment of urban American Indians aged 25+ jumped from 8.7 to 11.2 years. The urban American Indian cohort which is now at retirement age is likely to have lower educational achievement patterns than subsequent cohorts whose members were raised in the enriched urban environment (Sorkin, 1972).

URBAN AMERICAN INDIAN ELDERS

American Indian cultures are diverse. The government recognizes 300 different tribes and 150 native languages continue to be spoken. Less than half of all American Indians or Alaskan Natives and one quarter of their total elderly populations live on the 278 reservations and 209 Native villages. Nearly half (48%) of all American Indian elderly lived in urban areas at the 1980 US Census, the remainder of the population was located in rural areas and reservations (AARP, n.d.; Baker, Kamikawa, Espino & Manson, n.d.).

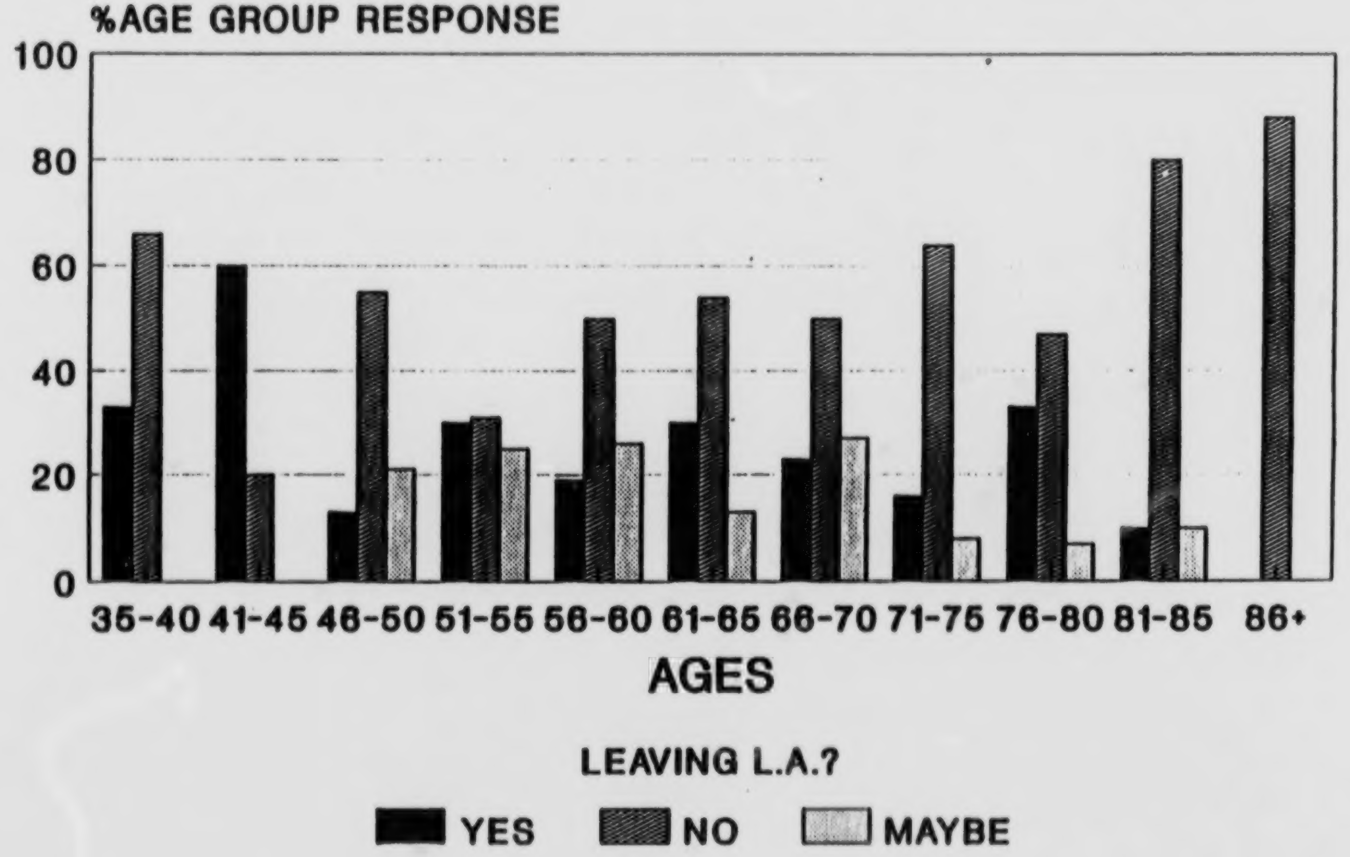
The number of American Indians living to old age is increasing and will have its greatest impact on urban areas. The proportion of American Indian elders increased by 65% between the 1970 and 1980 US Censuses, a rate twice that of white and black U.S. populations (AARP, n.d.). In part, this rate of increase may be an artefact of the census collecting methodology in 1970 (Meister, 1978). The number of elders is projected to double by the year 2000 (Baker, Kamikawa, Espino & Manson, n.d.). Most contemporary older American

Indians do not intend to return to their natal reservations (Kramer, 1988; Kramer & Hyde, in prep.; Weibel-Orlando & Kramer, 1989). As shown in Figure 1, the commitment to remain in cities is strongly associated with age. As the number of elders living in cities increases, urban areas can be expected to support the majority of older American Indians.

Chronological age is not a clear indicator of gerility in American Indians (Eck & St. Louis, 1972). The National American Indian Council on Aging (1981a) using the OARS instruments on a national sample, found that American Indians at middle-age suffered impairments which are characteristics of the general US population aged 65+. On reservations, individuals appeared aged at 45+ years and in urban areas, American Indians were aged by 55+ years. The life expectancy and longevity of American Indians remains below that of the general US population although those rates have shown improvement since World War II (NICOA, 1981a; Rhoades, D'Angelo, Hurlburt, 1977). The average life expectancy of American Indians is eight year less than non-Indians. Title VI of the Older Americans Act recognizes the need to provide support services to older American Indians living on reservations who may not yet be 60+. That waiver is not generally extended to elders living in urban settings.

American Indians do not define aging by chronology. The American Indian community both on and off reservations uses social role functioning (e.g., grandparenting) and decline in

GEOGRAPHIC STABILITY OF POPULATION PLANNING TO LEAVE LOS ANGELES?



N = 288

FIGURE 1

Source: Kramer, BJ (1989). Study of Urban American Indian Aging presented at the annual meetings of the American Society on Aging, Washington, DC physical activities as indicators to define which individuals are considered "elders" (Weibel-Orlando, 1988; 1989). Treating elders according to their abilities is rooted in cultural practices. The notion of calendar date birthdays and attendant celebrations of life stages was only introduced during the reservation period. This notion of aging has not been universally accepted as normative (Williams, 1980).

American Indian elders traditionally received support through the extended family network. However, increasing acculturation has eroded these important social roles and obligations. Arguments that the extended family is universal and pan-Indian (Red Horse, et al, 1978) are seemingly contradicted in some urban areas (Dukepoo, 1980). John (1985; 1988) summarizes the arguments as based in part on differences in definition of the extended family. No study has accounted for the impact of socioeconomic or cultural differences on the treatment of the elders. Highly individualistic cultures such as Apache traditionally did not provide high levels of support to frail elders (Cooley, Ostendorf, Bickerton, 1979). In a Los Angeles sample of elders from 91 tribal affiliations, the extended family did operate to provide informal support to frail elders (Kramer, 1990).

Urban and national American Indian organizations have been concerned that urban elders suffer from isolation and loneliness. In Boston, community members recommended intergenerational activities which would diminish these problems (Lyon, 1978). In contrast, peer group activities were the favored solution in Los Angeles (Los Angeles City/County Native American Indian Commission, 1982; Weibel-Orlando & Kramer, 1989). Nevertheless, elders in Los Angeles prefer to volunteer for activities which promote their intergenerational social roles as advisors, counselors and teachers (Kramer & Hyde, in prep).

SOCIOECONOMIC PROFILE OF URBAN AMERICAN INDIAN ELDERS

Manson (1988) analyzed the demographic characteristics of older American Indians based on the 1980 U.S. Census. The Census information was tabulated in such a way that analysis examined urban and rural differences in that population rather than off-reservation and on-reservation differences. In no region did the income of urban American Indians age 65+ equal that of whites (Table 1). Approximately one third of urban American Indians have incomes below or slightly above (25%) the poverty in contrast to one fifth of whites who live at that level of poverty (Table 2). Despite the income difference, there are no substantial differences in the labor participation and employment of whites and urban American Indiana aged 65+ (Table 3).

Age is associated with greater social and economic needs. About half the urban American Indian population age 75+ lives with family members and 16% of these families can be expected to be impoverished. American Indian families with elders in residence have three times the proportion of their population living in poverty as compared to whites. Manson (1988) notes that generalizations about family support systems must be tempered with knowledge that scare and irregular financial resources may co-determine extended family residence along with cultural norms for this behavior. Approximately one third of the 75+ urban American Indian population lives alone. Greater use of nursing homes is found among urban rather than rural American Indians and may be related to availability and market factors rather than to differing levels of need.

TABLE 1. AMERICAN INDIANS AGE 65+ BELOW POVERTY LINE BY REGION AND BY URBAN VERSUS RURAL IN 1979 (IN PERCENT)

AREA	URBAN	RURAL
NORTHEAST	24.1	27.7
MIDWEST	25.8	37.0
SOUTH	28.8	35.7
WEST	20.6	43.6

TABLE 2. A COMPARISON OF AMERICAN INDIAN AND WHITE PERSONS 65+ AT 125% OF THE POVERTY LEVEL BY REGION AND BY URBAN VERSUS RURAL FOR INDIAN PERSONS (IN PERCENT)

AREA	WHITES	AMERICAN INDIAN	
		URBAN	RURAL
NORTHEAST	19.0	35.5	35.2
MIDWEST	19.8	39.2	49.4
SOUTH	19.6	41.0	47.8
WEST	13.8	32.0	55.1

TABLE 3. A COMPARISON OF AMERICAN INDIAN AND WHITE PERSONS 65+ IN LABOR FORCE CHARACTERISTICS (IN PERCENT)

	URBAN		RURAL	
	WHITE	INDIAN	WHITE	INDIAN
PERCENT EMPLOYED	12	11	12	10
PERCENT UNEMPLOYED	1	1	1	1
PERCENT NOT IN LABOR FORCE	87	88	88	89

Source: Manson, S.M. (1988) Older American Indians: Status and issues on income, housing and health, paper presented for the AARP and related conference entitled: "Toward Empowering Minority Elderly: An Institute of Alternatives and Solutions" held in St. Louis, September 8-9, 1988.

HEALTH PROFILE

The Urban Health Care Setting

Unlike reservations where comprehensive medical evaluation and treatment are provided through Indian Health Service, these benefits may not be available in urban areas (Smith, 1987). The general misconception that all American Indians receive free medical service has frequently impeded health care delivery to urban American Indians. Consequently, few urban elders seek other public health services (NICOA, 1981b). Reservation-based Indian Health Service care ceases to be available 120 days after leaving a reservation and the federal responsibility is transferred to the states. Services are resumed when an individual returns to the reservation. In the past, health care benefits were described as a major incentive for returning to reservations after retirement in a city (Sorkin, 1978; Taylor, 1986 citing Fuchs, 1974). However, Indian Health Service does not consider long-term care as part of its mandate. Those elders living off reservations are considered the responsibility of state health care systems (Stuart & Rathbone-McCuan, 1988).

The gap in medical care to urban American Indians was reduced after 1977 when Indian Health Service began to assist in the implementation of urban health projects (Taylor, 1986). The 37 projects in operation offer a variety of programs. Some operate outreach and referral programs, and others provide comprehensive ambulatory care. The most extensive programs, such as those in Los Angeles, Minneapolis, Milwaukee, Seattle and Tulsa, have established a diversified funding base and are not solely reliant on Indian Health Service. However, the bulk of urban health clinic funding is allocated to reducing alcoholism and to serving a young population (American Medical News, 1984). Indian Health Service has not budgeted geriatric services and requires third party payment for some chronic disease treatments such as dialysis (Cook in U.S. Senate, 1989). Data collected from patient records at urban Indian health clinics in Oklahoma revealed low rates of insurance coverage among American Indians of all ages (Taylor, 1986).

There is no comprehensive data base on urban American Indian elderly health problems and health care needs. Indian Health Service collects no systematic data on diagnostic patient care from its urban health project providers. Nor does Indian Health Service publish vital statistics or population characteristics for urban American Indians except where this data is included with national level data on reservation states. Likewise, the National Center for Health Statistics and other sources have no data on urban Americans Indians.

Health Profile of Urban American Indians

The American Indian Physicians Association (1978) projects that American Indian elderly share the general health characteristics of the American Indian population at large. Obesity is common and is a risk factor for cerebrovascular disease, diabetes, cardiovascular disease and gall bladder disease. There is a high frequency of cataracts. Rheumatoid arthritis appears to occur with higher frequency than among non-Indians. High obesity, diabetes, cigarette use plus moderately elevated blood pressure and serum cholesterol levels are consistent with high cardiovascular mortality and morbidity.

Taylor (1986) conducted a survey of 1000 medical records collected at urban Indian Health clinics in Tulsa and in Oklahoma City in 1983 - 1984. The median age of the research population was 30.5 years and 8.1% of the records reviewed were of persons 65+. The five most frequent diagnoses were for diabetes, hypertension, physical examinations, contraception and prenatal care. Taylor concluded that the urban population had similar health needs and physician office visiting patterns as the reservation-based population. However, urban American Indians received significantly less primary care at the health clinics than either the reservation population served by Indian Health Service or the general U.S.

population. The reasons for the findings are not clear. Those using the urban health care clinics tended to be the most impoverished with median incomes lower than the national Indian average. Two thirds of those using the clinics had no health insurance.

Recognizing that urbanization and adoption of western European life styles have been associated with increased cardio-vascular risk, Gillum, Gillum and Smith (1984) assessed the American Indian population living in Minneapolis. The research sample consisted of 213 persons aged 16 - 84 years. Twenty persons (9.38%) were 55+ years. The findings indicate that the American Indian population of Minneapolis is at risk for heart disease and stroke. The high frequencies of obesity, diabetes and serum cholesterol are consistent with high rates of cardio-vascular mortality and morbidity. Unlike either black or white U.S. populations, no sex differences for risk factors were found. A rigorous program to reduce risk and control chronic disease was recommended.

Health Profile of Urban American Indian Elders

Three surveys of older urban American Indians report on their health status in various settings: nation-wide (NICOA, 1982; John, 1985), Phoenix (Eck & St. Louis, 1972) and Los Angeles (Weibel-Orlando & Kramer, 1989). Nationwide older urban American Indians responded on self-reported status to enjoy better health than their reservation peers. In contrast to reservation elders, the majority of older urban American Indians reported that major health problems do not interfere with their activities. Life satisfaction correlated with positive self-reporting of health and consequently was higher for urban American Indian elderly. Physical health contrasts to the lower self-reported levels of emotional well-being and satisfaction of urban American Indians in comparison to reservation populations (John, 1985).

In Phoenix, 70% of those 55+ years felt their health was average or better for persons of their age. The common health problems reported were: diabetes; arthritis/rheumatism; blood pressure; sight and hearing. Seventy per cent reported needing no addition health services. Of the 30% who needed more health services, half specified needing additional financial assistance to treat medical problems (Eck & St. Louis, 1972).

In Los Angeles, 61.5% of those sampled reported having health problems at the time of interview despite the generally positive self-reporting on health status. Nevertheless, on a four point scale of health ratings, 51.9% reported themselves to be in excellent to good health, 33.6% reported being in fair health and 14.5% reported being in poor health. The percentage of those reporting poor health is twice as large as the general population of 65+ in Cleveland (Weibel-Orlando & Kramer, 1989).

The Los Angeles sample of respondents 45+ did not compare favorably on morbidity rates to either the national American Indian sample of elders aged 45+ or to the Cleveland general population sample of 65+ (Table 4). Los Angeles elders reported higher frequencies of eye disease, hypertension, diabetes, asthma, stroke, speech pathologies, liver disease, amputation, and cancer than American Indian elders nationwide (Weibel-Orlando & Kramer, 1989). Similar complaints were noted for elders living in Phoenix.

In comparison to the general U.S. urban sample reported in Cleveland, American Indians in Los Angeles have dramatically higher frequencies of certain diseases. For instance, diabetes occurred 4.3 times more frequently and liver disease occurred 8.7 times more frequently. Hypertension was reported by nearly a third (30.7%) of the respondents aged 45+. Although no comparable data was collected by NICOA, the high frequency of dental problems was noted in Los Angeles as the third most frequently identified health problem.

TABLE 4. COMPARISON OF PREVALENCE OF MORBIDITY FOR SELF-REPORTED DISEASE OR SPECIFIC SYMPTOM BY PERCENT IN L.A. INDIANS 45+, NATIONWIDE INDIANS 45+, CLEVELAND GENERAL POP. 65+ AND U.S. GENERAL POP. 45+

HEALTH PROBLEM	L.A. 45+ (EXCEPT HOMELESS)	NATIONAL INDIAN 45+*	CLEVELAND ALL RACES 65+*	NATIONAL ALL RACES 45+*
EYESIGHT	65.9	54.6	40.4	----
ARTHRITIS/RHEUM.	36.4	42.6	41.9	26.9
HYPERTENSION	30.7	19.3	16.5	25.9
HEARING PROBLEMS	21.0	44.4	37.3	15.9
DIABETES	19.8	12.5	4.2	5.2
SLEEP PROBLEMS	17.0	30.4	33.5	----
HEART PROBLEMS	14.8	16.1	15.6	12.9
BREATHING PROBLEMS	13.1	34.0	23.0	----
ALLERGIES	12.0	----	----	9.0
HEADACHES	11.0	28.5	14.8	4.1
ASTHMA	8.1	4.3	3.2	2.8
STROKE	4.9	3.2	4.6	----
SPEECH PROBLEMS	4.6	1.4	1.2	----
LIVER PROBLEMS	3.5	1.6	0.4	----
KIDNEY STONES	3.2	8.9	1.9	----
MENTAL ILLNESS	3.2	7.9	4.4	----
AMPUTATION	2.8	1.2	2.1	----
CANCER	2.5	1.1	0.9	----
NUMBER OF MEN	99		687	
NUMBER OF WOMEN	184		1037	
TOTAL NUMBER	283	712	1834	

* NICOA

** U.S. Dept. of Commerce, 1988

Excerpted from Weibel-Orlando, J. and Kramer, B.J. (1989). The Urban American Indian Elders Outreach Project, Final Report of Administration of Aging Demonstration Project. 90 AMO273, Los Angeles County, CA: County of Los Angeles.

NUTRITION

Although the malnutrition is considered common among American Indians (American Indian Physician Association, 1978), it seems to be limited to reservation populations. A study of older urban American Indians in Lincoln Nebraska determined that there were no significant differences from an older non-Indian urban population (Betts & Crase, 1986). These two elderly populations were both below recommended levels in total food energy, vitamin A and calcium intakes. Poverty characterized 80% of the American Indians surveyed. However, extensive nutritional inadequacies were not found in contrast to reports on elderly American Indians living on reservations.

MENTAL HEALTH

Utilization of Mental Health Services

The low use of mental health practitioners by elderly American Indians indicates either less need than the general American Indian population or more selective barriers for this aging population (Assoc. of American Indian Physicians, 1979). To some extent both of these variables interact. The positive role of the elder has been equated with the low incidence of self-destructive behaviors such as alcoholism and suicide (Assoc. of American Indian Physicians, 1979; McIntosh, 1984; McIntosh & Santos, 1981). On the other hand, the notion of evaluating and treating mental health is highly stigmatized in the American Indian community.

The utilization statistics of Indian Health Service do not apply directly to urban American Indian elders. On reservations, the most frequent diagnosis of those under 45 years is alcoholism. However, the majority of diagnoses for anxiety occur in the 65+ population. This population is also seen most frequently for physical complaints of chronic illnesses.

(Rhoades, et al, 1975; 1980). No comparable data base exists for American Indian elders living off reservations.

Stress and Anxiety

Stress was a persistent symptom of the chronically ill older American Indians studied in the Pacific Northwest (Manson, Murray, Cain, 1981). Older urban American Indians were more disadvantaged than reservation-based elders. The majority of urban elders in this sample were unaware of psychological, social or economic resources which might ameliorate their conditions. When questioned, they expressed concern about "what people would think" if they solicited help.

Differences between urban and reservation dwelling elders were noted at the second annual National Indian Council on Aging annual meeting, held in Billings, Montana in 1978 (Manson and Aubrun, 1979). Questionnaires were distributed to 1300 persons in attendance and, of the 20% completed, 42% were received from urban elderly. While the aggregate was generally positive, urban elders reported less satisfaction than their reservation counterparts on the following yes/no questions: 1) proud of personal appearance; 2) attained most of their life goals; 3) felt good about themselves; 4) functioned adequately; and 5) liked the present quality of their life.

Peer group dissatisfaction was expressed more significantly in urban areas. Dissatisfaction was associated with the following urban problems in comparison to reservations: 1) less planned entertainment for American Indian senior citizens; 2) greater isolation; and 3) greater transportation problems.

Little is known of the coping strategies of American Indian elders. Indications of the importance of passive forbearance as an adaptive technique are derived from a limited comparative study of rural American Indian and non-Indian care-givers to elderly family members in Washington state. In contrast to non-Indians the American Indian care-givers reduced stressful feelings of frustration, anger and guilt by passively accepting their situation (Strong, 1984). Given the reluctance of elders to access non-Indian service providing agencies, it is likely that passive forbearance also mitigates the inadequacy of resources. If this is the case, such a strategy may incidently suppress behaviors to seek, access or use needed support services.

Psychology of Aging

American Indian elders have been described as the heart and soul of the extended family and consequently of the community (Lyon, 1978). Their accrued knowledge and experience translated as prestige in old age. Recognized as widely experienced and knowledgeable, younger community members turned to them for advice and counsel. This role has been eroding over the last several decades, particularly in cities according to American Indian leaders. Williams (1980) notes that better educated, younger American Indians are assuming political roles which had formerly been dominated by elders.

Little is known about the psychological status of aging among American Indians. In reviewing the literature Manson and Pambrun (1979) found that the few publications which touched on this issue were either heavily psychoanalytic or descriptive. In general, the elders' point of view and their concerns are not represented in the literature.

While not focusing on psychological issues, some concerns shared by urban elders were captured in needs assessments. Health issues were considered a priority in Los Angeles (Weibel-Orlando & Kramer, 1989), the lack of resources on reservations discouraged a change of lifestyle in San Diego (Dukepoo, 1980), and concerns about limited finances and about the future have been voiced (John, 1985).

A small sample among the oldest old of American Indian and non-Indian women living in Oklahoma noted different processes of disengagement (Richeck, Chuculate, Klinert, 1971). American Indian women disengaged from work, peers, optimism, and general satisfaction with their environments but not from children, parents and authority figures. In contrast, Caucasian women disengaged from children, parents and authority figures as they aged. This was explained anecdotally as resulting from the life-long maintenance of the American Indian extended family and from American Indian religious beliefs which depressed the hope index used in this study. Other differences noted were that 1) American Indian women hold significantly more positive attitudes toward children and authority figures than do whites; 2) when perceptions of life experience are rated, Indians hold themselves in higher self-esteem than whites and were significantly more optimistic; 3) whites hold a more positive attitude to work than do Indians; and 4) Indian women report their happiest times occurring at an average age of 10 years younger than non-Indian women.

Mental Health Screening Instruments and Practice

The cultural relevance and validity of psychometric tests for older American Indian populations continues to be an area of needed research. The CES-D screening instrument was tested for internal consistency and validity in screening depressive symptoms of elders on three Pacific/Northwest reservations (Baron, et al, n.d.). Despite findings of high validity and consistency for this cultural group, the high incidence of chronic illness among older American Indians and its expression as somatic complaints related to daily activities and pain compromised the instruments validity for older American Indians.

The role of the elder as a mental health practitioner is implicit in recommendations for use of network therapy in treating urban American Indians. This therapy focuses on the extended family and encourages individuals to perceive themselves as embedded in and expressive of their community (LaFramboise, 1988; Red Horse, 1982). The elders themselves have taken on this role in offering religious and personal counseling (Price, 1981).

ACTIVITIES OF DAILY LIVING

Analyzing the Los Angeles needs assessment, Kramer (1990) found that the majority of respondents were not impaired in any Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). However, the majority of those reporting impairments were unable to function independently in more than one ADL or IADL. Age correlated with having multiple impairments. Those aged 60+ years tended to have more impairments. Statistically significant differences between persons younger than 60 years and those older than 60 years occurred for transfer, mobility in the home, money management, shopping, transportation, meal preparation and light housework. The greatest number of impairments and the strongest relationships to age occur in the IADL categories.

TABLE 5. FREQUENCY OF IMPAIRED ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING BY AGE

ACTIVITIES	< 60	60+	X^2
BATHING	6	16	(2,N=286)= 6.71, p=<.035
DRESSING	5	12	(2,N=286)= 5.11, p=<.078
TOILETING	4	10	(2,N=286)= 3.68, p=<.159
TRANSFER*	5	18	(2,N=284)=10.59, p=<.005
FEEDING	2	5	(2,N=287)= 1.82, p=<.178
MOBILITY IN*	9	28	(2,N=283)=14.65, p=<.001
TELEPHONE	3	13	(2,N=294)= 9.15, p=<.010
MONEY MGMT.	4	17	(2,N=290)=12.06, p=<.002
SHOPPING	15	41	(2,N=294)=18.18, p=<.0001
TRANSPORTATION	15	41	(2,N=292)=20.35, p=<.0001
MEAL PREPARATION	13	31	(2,N=289)=12.20, p=<.002
HOUSEWORK	15	42	(2,N=290)=20.99, p=<.0001

*Statistically significant difference found with X^2
Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco.

TABLE 6. TOTAL NUMBER OF IMPAIRMENTS REPORTED IN ADL AND IADL

ACTIVITIES	< 60	60+	TOTAL
ADL	31	89	120
IADL	65	185	250
TOTAL	96	274	370

Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco.

All frail elders received informal and formal assistance although in no case did any elder perceive the help to be sufficient (Weibel-Orlando and Kramer, 1989). Although most elders in Los Angeles live alone or with a spouse, it is the frail community members who are found in large multigenerational households (Kramer, 1990). Quite often unmarried grandchildren or children are the care-givers. Clearly the family role in these cases is not diminished. However, accessing formal services may have been somewhat reduced. Until a crisis stage is reached, there may be little incentive to endure the bureaucratic application procedures for supportive services. Furthermore, the eligibility requirements of some agencies may not support the extended family.

SUPPORT SERVICES

Urban American Indian elders are more likely than their reservation peers to rely on formal assistance programs (Dukepoo, 1980; John, 1985). Extracting data from the NICOA (1981a) study, the majority of assistance was needed in instrumental activities of daily life and the priority need for urban elders was for information and referral (John, 1985). Although the urban sample of the NICOA study was so limited that one of that project's researchers has warned against generalization (Curley in U.S. Senate, 1982), the preponderance of needs for non-personal care are confirmed by other assessments (NICOA, 1978; Kramer, 1990; Weibel-Orlando & Kramer, 1989). Health care is a prominent concern of urban American Indian elders (Lyon, 1978; NICOA, 1978; Weibel-Orlando & Kramer, 1989).

A number of barriers reduce access to non-Indian health and supportive services (Bell, Kasshau & Zelman, 1978; Lyon, 1978; NICOA, 1982). American Indians are not adept at cutting through the "white" tape and are unwilling to accept services delivered as charity. Distrust, lack of communication and cultural insensitivity too often characterize interactions between American Indian elders and non-Indian service providers. Instead, elders rely on friends and family resources, do not complain, prefer to accept pain and treat themselves. Poverty reduces health care to a last priority. Non-Indian health and Title III service providers have failed to attract older American Indians in cities such as Minneapolis where the American Indian community has been described as a closed network (Red Horse, Lewis, Feit & Decker, 1978) and where there is a general preference for care by American Indian providers (DeGeynt 1973).

Red Horse (1982) proposed that information flow from the aging network to the American Indian community would be enhanced by empowering the community service groups which are in-place. These include both organizations and families. Demonstration projects in Montana (Montana United Indian Association, 1974), Albuquerque (NICOA, 1982) and in Los Angeles (Weibel-Orlando & Kramer, 1989) have successfully linked elders to aging network services through peer group outreach programs. Information and referral alone are not sufficient to meet the multiple needs of frail American Indian elders. The case management approach taken by these outreach projects has been effective. Without the outreach intervention by peer paraprofessionals, access to support services would not have occurred.

American Indian elders have pinpointed their needs for support services (Lyon, 1978; Weibel-Orlando & Kramer, 1989). An American Indian senior center would be enthusiastically received by the elders in Los Angeles. Their top ranked priorities for facilities, services and traditional activities are shown in the Table 7.

TABLE 7. PRIORITIES FOR AN AMERICAN INDIAN SENIOR CENTER

I. FIVE TOP RANKED OF 20 FACILITIES

FACILITY		% THINKS THIS IS VERY IMPORTANT OR IMPORTANT
KITCHEN	(N=321)	97.8
DINING ROOM	(N=314)	97.5
MEETING HALL	(N=314)	96.8
CLINIC	(N=306)	94.8
POWWOW HALL	(N=308)	89.0

II. TEN TOP RANKED OF 17 TRADITIONAL ACTIVITIES

ACTIVITY		% WOULD USE	% WOULD HELP
POTLUCK MEALS	(N=310)	90.3	8.7
POWWOWS	(N=305)	83.3	8.9
CRAFT CLASSES	(N=300)	80.0	12.3
BINGO	(N=106)	79.2	12.2
INDIAN HISTORY	(N=297)	77.4	9.4
INDIAN STORYTELLING	(N=289)	70.6	11.1
L.A. INDIAN HISTORY	(N=297)	68.7	7.2
GIVEAWAYS	(N=281)	67.6	5.7
CAMPOUTS	(N=281)	66.9	7.1

III. TEN TOP RANKED OF 33 GENERIC SERVICES FOR SENIORS

SERVICE		% WOULD USE	% WOULD HELP
EYE EXAMINATIONS	(N=304)	91.1	1.6
BLOOD PRESS. TESTS	(N=303)	89.4	2.2
CARDIO-VASC. EVAL.	(N=305)	87.5	1.6
DIABETES SCREENING	(N=300)	86.3	1.6
FIELD TRIPS	(N=145)	82.8	0.0
LEGAL AID	(N=301)	80.4	3.3
DENTAL CARE	(N=142)	79.6	0.0
TRANSPORTATION	(N=303)	76.9	4.0
EXERCISE CLASS	(N=147)	76.9	0.0
TAX ASSISTANCE	(N=292)	73.3	4.4

Source: Kramer, B.J. (1990). Study of urban American Indian aging, presented at American society of Aging annual meetings, San Francisco, excerpted from Weibel-Orlando & Kramer, 1989.

THE LITERATURE AS A DATA BASE

The literature does address diverse issues relating to urban American Indian aging. However, the research is sparse and is not sufficient to construct a comparative data base. Aggravating the paucity of data, is the use of unique survey instruments which elicit information on scales which cannot easily be compared.

Literature on the adult experiences of the contemporary urban elder's cohort focuses on problems, such as alcoholism, and on institutions, such as the development of pan-Indian organizations. The literature does not offer insight into successful adaptations of individuals over the course of several decades residence in urban areas. The quality of life of urban elders is unknown.

As a general profile, urban American Indian elders age in place and do not return to reservations. This population reports high indices of chronic health problems. Lack of health care is a major concern. Despite high levels of stress, mental health services are not accessed. While most urban elders live alone or with a spouse, frail elders tend to reside in extended family settings. High levels of poverty impact both the elderly and their families and effectively depress the level of support available in intergenerational households. Multiple impairments correspond with age and are most frequently in the instrumental activities of daily living. Elders age 60+ are significantly more impaired than those aged 45-59 years. Peer paraprofessional outreach is particularly effective in linking elders to aging network services.

VII. AN AGENDA FOR FUTURE RESEARCH QUESTIONS

The existing literature on urban American Indian aging consists largely of ground-breaking research. Research findings could not be tested against extensive data bases or comparative studies. Therefore, many reports recommend areas for future research to clarify the results or conclusions reported. The broad agenda for future research represents a compilation of questions posed in the literature which is cited in the annotated bibliography. Additional research questions derived from analysis of those sources were included. Seventy-five avenues of inquiry are recommended.

The agenda for future research calls for a national response. The scale of research to date has not been able to account for regional and inter-tribal variations, nor does longitudinal data exist to define the normal process of aging. The methodology and validity of important local studies should be carefully considered. As Larry Curley warns in testimony to the US Senate Select Committee on Indian Affairs (1982), the findings of the small sample or urban elders gathered for the NICOA (1981) cannot be generalized. The research questions are intended to suggest a program of inquiry which will define the unique social, cultural, psychologic and physiologic factors of urban American Indian aging. Research questions related to programs and policies which suggest best practice models are included.

The future research questions are organized into general categories. Where possible, questions have been grouped to represent a line of theoretical or methodological inquiry. Given the paucity of data, both basic research questions and their practical application have been grouped whenever possible.

The questions posed in the agenda are arrayed in topical rather than priority classifications. These categories are not discrete and content areas do overlap somewhat. Nevertheless, this serves as a convenient organizational device. As a compilation of research questions, the agenda is biased to the greater proportion of studies in the health and mental health fields. Each topical area deserves equal attention in developing comprehensive knowledge base on urban American Indian aging.

The topical categories for research questions are: 1) The Aging Process: In General; 2) Supportive Services and Senior Citizens Programs; 3) Policy; 4) Long term Care; 5) Socio-Behavioral and Cultural Factors and their Impact on the Aging Older Adult and on Health and Support Service Delivery Systems; 6) Health Program Needs; 7) Mental Health; 8) The Aging Process: Biomedical; and 9) Demography.

THE AGING PROCESS: IN GENERAL

- What is the urban American Indian elder's point of view regarding the aging process and the social/cultural roles of elders? How can the elders' conceptualization be integrated into programs or policy development to promote the goals of these older Americans?
- Do urban American Indians under the age of 60 years have the same characteristics and needs as those who are 60+? What are the needs and characteristics of the urban cohorts aged 60-64, 65-9, 70-74, 75-80 and 80+ years?
- What is the urban American Indian orientation toward retirement and post-retirement activities?
- Is age a clear indicator of gerility? To what extent does the social definition of aging reflect physical decline in the aging process? Does a differing sociocultural definition of aging which is not based on chronological age, affect urban American Indians' perception and utilization of Older Americans Act programs?
- Little is known about the quality of life of Indian elderly on reservations and less is known about urban elders. How do quality of life issues for American Indians relate to the goals of the Older Americans Act?
- What factors have affected the aging cohorts of urban American Indians? How this population has aged should be examined through a life-course perspective which examines the interrelationships of social structures, sociohistorical period, sociodemographics, personal biographies, life cycle stage, migration history, personal and adaptive resources, life events and well-being.

- Are standard physical and mental health measures effective in evaluating urban American Indians? What factors impinge on their effectiveness (e.g., linguistic, conceptualization, sociolinguistic, physiologic factors)?

- Controlling for socioeconomic affects, is there a unique process of aging among American Indians with clear and consistent definition?

- What factors account for the differential aging processes noted among reservation and urban American Indian populations by NICOA? What are the problems, causes and potential solutions to the rapid aging of the reservation population at age 45+ and urban population at age 55+ in comparison to the general population at age 65+?

SUPPORTIVE SERVICES AND SENIOR CITIZENS PROGRAMS

- How does the type and degree of need by the current cohort of urban American Indians and Alaskan Natives aged 45+ and aged 55+ differ from the type and degree of need of other urban populations at age 60+?

- What adaptations in service delivery methodologies are required to insure that urban American Indians receive supportive services which are needed?

- How can urban elders be encouraged to seek assistance and/or accept outreach efforts rather than to continue to "remain invisible" to the aging network service providers?

- Under what circumstances does integration into the generic aging network occur?

- How important are friends, siblings, distant relatives in social networks of urban American Indian elderly? What types of support can these informal networks provide? What types of services must be provided by formal interventions?

- Since peer outreach strategies have been demonstrated to be effective in contacting urban American Indian elders, what types of training programs can be implemented to more effectively support the role and prolong the commitment of paraprofessional staff to work on behalf of their community's elders?

- What are the roles of the extended family in assisting elders to obtain services and in providing information about support services? How do these roles vary in relation to service-specific areas, to life domains and to cultural norms?

- Does participation in Older American Act supportive services undermine social relationships and cultural values of urban American Indians by its restrictive entitlement to age 60+? In this regard, are there significant differences related to culture or to residence in cities or on reservations?

PROGRAM AND POLICY ISSUES

- What factors explain the national variation in usage by urban American Indians of services available through Title III providers and through multipurpose urban American Indian organizations? Are certain local or state level targeting strategies particularly effective and do they suggest best practice models?
- What models and strategies would encourage greater participation of urban American Indian multipurpose organizations in the aging network and in the Title III contracting process?
- How are the needs of urban American Indian elders different from the needs of rural/reservation American Indian elders?
- To what extent are the federal, state and local aging networks impacted by the need to provide outreach and services to American Indians?
- What barriers exist to accessing supportive services? What are the perceptions of Title III services and provider agencies? What factors promote/inhibit utilization of Title III services?
- What factors contribute to the continuing administrative neglect at federal, state, or local levels to provide services for older American Indians?
- What is the extent of political involvement of older urban American Indians and what are the outcomes of their political participation? How can political representation of older urban American Indians be enhanced at the local, state and federal levels so that policy development addresses their needs?

LONG TERM CARE

- What is the role of the extended family in providing long term care for frail elderly, what barriers militate against formal service delivery in those circumstances, which strategies and programs effectively support informal care-givers within the American Indian definition of family?
- What factors contribute to the higher rate of nursing home utilization in urban rather than reservation communities?
- What are the interrelationships of need for nursing home care, lack of formal supportive services for dependent urban elderly, availability of nursing home beds and profitability of nursing home enterprises in urban areas?
- Do cultural factors affect nursing home utilization when socioeconomic status, health care access and medicare/medicaid eligibility are held constant?

- What are the attitudes of older American Indians to different living arrangements such as institutional, independent and family settings?

SOCIO-BEHAVIORAL/CULTURAL FACTORS & THEIR IMPACT ON AGING OLDER ADULT AND ON HEALTH AND SUPPORT SERVICE DELIVERY SYSTEMS

- What is the meaning of aging to American Indian elders?
- What is the social context of aging for urban American Indian elders?
- What are the gender-specific relationships between life domains of psychologic and physiologic well-being and social support?
- What are the values associated with aging in the urban American Indian community? Are these values positive or negative? Are these values consistent across generations?
- What is the nature of the urban American Indian family and what is meant by family? Do the same definitions of extended family apply in contemporary urban settings as on reservations?
- What accounts for opposing claims by researchers that either the extended family is universal among American Indians at any location or that urban American Indians families tend to resemble middle class non-Indian families? Are differences based on socio-economic factors, cultural differences, cohort effects, or lack of consistent definition?
- Do urban American Indians recognize non-Indian roles for elders as appropriate? Do social roles differ significantly for elders living on and off reservations?
- What social, cultural and behavioral correlates of the physiological processes of aging, human development and disease onset occur over a lifespan? Both cross-sectional and longitudinal research is required.
- Are the few existing studies of contemporary urban American Indian communities sufficiently representative with respect to the elderly to describe the frequency of interaction, types of activities, direction, flow and types of assistance, or proximity of kin? What methodology will effectively describe similarities and differences based on the community's composition, development, size, location and economic opportunities?
- Are there sex differences or asymmetry in contact and assistance within the social network? How does this affect the delivery of informal and formal support services? Which individuals can be identified as likely to experience greatest risk in urban American Indian communities?
- What cultural values inhibit or encourage early diagnosis and treatment of illness or categories of illnesses?

- Although the literature recognizes that new intergenerational relationships are developing, the affect on elders has not been researched. Are American Indian elders under social pressure to interact in new way with younger generations as age stratification develops, kinship ties are weakened and employability declines? Do changing relationships between grandparents and grandchildren affect the positive aspect of aging (e.g., transmission of culture)? What intergenerational relations characterize the contemporary urban American Indian family? What adaptations have occurred in the American Indian family structure in the contemporary urban environment?

- How does life experience, indigenous cultural values and social integration impact on ethnicity as a resource in the process of aging?

HEALTH PROGRAM NEEDS

- What are the health needs, morbidity and mortality of older urban American Indians? What methodology will efficiently produce a data base in the absence of systematic Indian Health Service reporting?

- Obesity is a precursor to cerebrovascular disease, diabetes, gall bladder disease, and cardiovascular disease. What types of programs would be effective in targeting obesity in older American Indians?

- What programs can be effective in providing treatment for cataracts and other eye disease in older American Indians?

- What economic projections can be made to predict the demand to Indian Health Service of care for chronic disease in the elderly? How will available care at urban Indian Health Service clinics compare to county health clinics, private and Prepaid Health Plans?

- Is Indian Health Service facing an expanding population at higher risk if American Indians at age 45-64 share similar health and functional characteristics to non-Indian at 65+?

- How do the health care utilization patterns compare at urban Indian Health Service clinics and at other emergency and primary health providers? What are the barriers to accessing medical care and to receiving quality care? To what extent do urban American Indians delay treatment or ignore health problems in the absence of an Indian Health Service system of care?

- Which risk reduction strategies or treatment focuses will successfully reduce the higher incidence of disease affecting older urban American Indian women?

- Do conceptual and explanatory models of diseases such as diabetes, rheumatoid arthritis and hypertension compare with the standard diagnostic criteria of medical practitioners? How can conceptual models best be aligned to improve successful treatment of disease, patient compliance to prescribed therapies and recovery time?

- What are the culturally appropriate contexts for health and mental health services delivery, treatment and rehabilitation and what factors unify treatment cross-culturally among older American Indians regardless of location?

- Do the self-reported lower ratings of health and activities of daily life of older urban American Indians than among non-Indians disappear when socioeconomic factors of income, education, gender and age are controlled through multivariate analysis?

- What is the interaction of tribal affiliation and age on the effectiveness of pharmacologic and nonpharmacologic treatments? Does this interaction vary intertribally or vary from other ethnic and minority groups or from the general population?

- What types of rehabilitation strategies and therapies are most effective in successful treatment and patient compliance to prescribed regimes? Can rehabilitation programs be linked effectively to other aging programs targeting older urban American Indians?

MENTAL HEALTH

- What factors account for the lower utilization of mental health services by older American Indians? Three major areas have been suggested in the literature: less need for mental health services than among the younger American Indian population, selective barriers to accessing services or lack of clarity in the definition of mental health. Research in this area must taken into account culturally specific tests and culturally specific data collection.

- Chronic diseases affect many older American Indians. How does the affect of chronic illness expressed as somatic complaints and as pain compromise 1) the validity of CES-D or other psychometric tests and 2) measures of activities of daily life?

- What factors contribute to the strong correlation of increasing age and diminishing diagnoses of alcoholism in this population?

- What criteria effectively define differential diagnoses for organic brain syndrome and affective disease among older American Indians of various tribal affiliations?

- What are the general attitudes and conceptualizations of illness and health care by older American Indians? Do these attitude vary significantly across tribal or regional boundaries?

- Do life satisfaction measures correlate with participation in senior citizen programs targeting older American Indians?

- What are the attitudes and coping strategies of American Indian care-givers and care-receivers? Do urban American Indians of various tribal and cultural backgrounds utilize passive acceptance as a coping strategy which minimizes feelings of anger and guilt toward the frail elderly care recipient? What culturally-sensitive mental health strategies best support the American Indian care-giver?

- How do older American Indians indicate their needs for assistance in activities of daily living and to whom? What strategies effect the most appropriate response from the informal and formal support system?

- How do older American Indians of various cultural backgrounds perceive the aging process?

AGING PROCESS: BIOMEDICAL

- Given the lower life expectancy and higher rates of certain chronic diseases, is American Indian aging a unique process?

- What factors explain the lower incidence of Alzheimer disease among American Indians?

- Why does rheumatoid arthritis appear to occur at greater frequency among American Indians? Are there risk factors which can be reduced?

- What is normative development over a life-time? To respond to this question, there is a need to produce a longitudinal database. Are there significant inter-tribal or intra-group variations?

- Do any physiological processes at the exclusion of socioeconomic factors account for the differential life expectancy of American Indians?

- Are there American Indian physiological differences which affect the aging process or which influence age-related disorders? One strategy might be to examine differences in physiological changes in persons at risk for disease due to genetic disposition in comparison to those at lower risk. (e.g., age of development of certain pathophysiologic features of disorders) to determine progress and variability of chronic disease across American Indian cultural groups and across ethnic groups.

- What accounts for differential morbidity and mortality rates of American Indians, from other minorities and from the general public?

- What risk factors for disease affect American Indians and does variability operate across cultural groups, socioeconomic groupings or the urban/reservation continuum? How does this variability compare to other ethnic groups?

- What physiologic changes occur within the normal aging process (e.g., glucose tolerance, cardiovascular status, hormonal secretions and immunocompetence in healthy samples).

DEMOGRAPHY

- Has the epidemiological transition occurred? Is the decline in infectious and parasitic diseases sufficient to fit the model of epidemiological transition to man-made and degenerative disease as major causes of mortality?

- Is there a cohort effect that Indians born at the turn of the century would be more likely to survive to old age than those born in the 1940s who are affected by man-made disease and stress? Does long-term residence in urban settings rather than on reservations have any significant impact on longevity, morbidity, or mortality?

- What proportion of American Indian elders reside in urban areas and in rural/reservation areas? For those urban elders who choose to relocate to a natal reservation, at what age and under what circumstances does such a reverse migration occur? What cohort effects correlate with the decision to age in place in urban environments or to relocate to reservations after retirement?

- What sociodemographic trends in population size and distribution, life expectancy, mortality, morbidity, dependency ratios, marital status, sex ratios and migration characterize older urban American Indians and to what extent do these differ from reservation cohorts?

VIII. AVAILABILITY AND ACCESS TO SUPPORT

METHODOLOGY

Survey of American Indian Organizations

Cities with high concentrations of American Indiaw were targeted to determine if local American Indian organizations were filling gaps in the aging network's services to older American Indians. The target cities were selected with input from the Office of Project Development, Administration on Aging and from Suzanne Harjo, President of the National Congress of American Indians. These cities are characterized by large, well-established American Indian communities. Typically, urban American Indian populations are dispersed within a Planning and Service Area and American Indian communities are not concentrated in distinct neighborhoods. Surveys were conducted with American Indian organizations in:

Los Angeles
Minneapolis
Omaha
Seattle
Boston
Phoenix
San Francisco
St. Paul
Tulsa
Portland
Dallas
Milwaukee
Oakland
Chicago
Oklahoma City
New York
Denver
St. Louis

A brief survey instrument was designed to assess the extent of programs and funding available for elders through urban American Indian organizations. The survey questionnaire was administered during a telephone call. The organizations were identified by American Indian staff at the County of Los Angeles Area Agency on Aging. The telephone surveys were also conducted by these staff, themselves urban American Indian elders. After the initial telephone contact, each organization was sent a letter of thanks and a brief description of the project goals. After all the questionnaires were completed and the data compiled, each organization was sent copies of the findings for comment and, if necessary, correction. Using this strategy we were able to gather additional information including the closure of the Native American Senior Center meal site in San Francisco. Corrections were made as indicated by American Indian organizations and the data analyzed by project staff.

Management Information System Reports

Utilization of Title III services was also examined in the Planning and Service Areas for the target cities above. Project staff contacted both State Units on Aging and/or Area Agencies on Aging for Management Information System (MIS) reporting on utilization of Title III services for fiscal year 1989. Contacts were made both by telephone and as written requests. Staff requested MIS data on unduplicated counts by ethnicity, for each service site and for each program. In addition, staff gathered information on the distribution of support services over the Planning and Service Area. Letters confirming the information and requesting additional information as needed were sent to each responding agency. The written communication was also used to verify and correct our data base.

Analysis of the MIS data was complicated by the lack of uniformity in collecting and reporting information throughout the country. The State of California provided the most detailed and useful information on ethnic group participation in each support service program. Other agencies limited data collection on ethnic group utilization patterns to congregate meals. Automation capabilities varied as well. Unduplicated counts of individuals served were available for Title III(c), and III(c)2 services and these data were used for comparison across Planning and Service Areas. MIS reporting for Title III(b) was inconsistent and often contained duplicated counts.

Data was arrayed using SAS and compared with the US Census 1980 population figures and with information received from the urban American Indian organizations.

UTILIZATION PATTERNS OF SUPPORT SERVICES

Decades ago, urban American Indian multipurpose organizations were developed to assist American Indians adapt to life off-reservations and to overcome barriers in dealing with non-Indian social institutions (Locklear, 1972). These organizations continue to provide generic services to American Indians of all ages. Consistent with the Bureau of Indian Affairs policy, American Indian elders are eligible for any program on the same basis as any other American Indian citizen (U.S. Senate, 1981:13-14).

In the eighteen cities targeted by this project, one half of the American Indian organizations also had specialized services for elders provided with funding from Title III of the Older Americans Act (Table 8). Other funding sources supplemented center activities. In addition to governmental support, grants contributions, donations and philanthropic funding provided substantial levels of support.

TABLE 8.
FUNDING SOURCES FOR INDIAN CENTER SERVICES

FUNDING SOURCE	NUMBER OF CENTERS (PERCENTAGE)
OLDER AMERICANS ACT - TITLE III	9 (50.0)
OLDER AMERICANS ACT - TITLE VI	1 (05.5)
COMMUNITY SERVICES BLOCK GRANTS	2 (11.0)
CITY FUNDING	4 (22.2)
COUNTY FUNDING	6 (33.3)
STATE FUNDING	4 (22.2)
PHILANTHROPIC FUNDING[1]	5 (27.8)
CONTRIBUTIONS/DONATION	6 (33.3)
GRANTS[2]	8 (44.4)

[1] Four of the sites receive United Way funding; one receives Salvation Army funding.

[2] Three of the sites receive unknown grant support; two sites receive U.S. Department of Agriculture Support; two receive private foundation grant support; one receives tribal support.

Significant differences in the range of services available corresponds with funding by Title III (Table 10). It appears that these Title III contractors are actively involved in the aging network. They provide twice the range of services which reported only general funding. Through coordination with the aging network an average of 14 support services are provided. It must be noted that there is a discrepancy between the survey's reporting of Title III funding with MIS reporting. Several center representatives were apparently unaware of their funding source through an aging network.

In Table 9 both direct provision and referral services are included together. All the Title III programs offer social activities and entertainment for elders, whereas only one third of the other programs had activities which might involve elders. Title III programs are more likely to provide congregate meals (88.8%) than non-OAA funded programs (33.3%). Likewise, home delivered meals are more than twice as likely to be available from Title III programs as Indian Centers. This proportion generally holds true for most services except health care and case management. In both instances, these programs are equally available and reflect the close associations between urban Indian centers and urban Indian health boards.

TABLE 9. COMPARISON OF RANGE OF SERVICES AVAILABLE IN OAA-FUNDED AND NON-OAA FUNDED INDIAN CENTERS

SERVICE	OAA FUNDED	NON-OAA FUNDED
CONGREGATE MEALS	8 (88.8)	3 (33.3)
MEALS ON WHEELS	5 (55.5)	2 (22.2)
TRANSPORTATION	6 (66.6)	5 (55.5)
SOCIAL ACTIVITIES/ENTERTAIN.	9 (100.0)	3 (33.3)
HEALTH CARE	6 (50.0)	6 (50.0)
HEALTH SCREENING	7 (77.7)	3 (33.3)
HEALTH EDUCATION	7 (77.7)	3 (33.3)
IN-HOME HEALTH SERVICES	7 (77.7)	2 (22.2)
CASE MANAGEMENT	3 (33.3)	3 (33.3)
INFORMATION & REFERRAL	8 (88.8)	6 (66.6)
LEGAL ASSISTANCE	6 (66.6)	4 (44.4)
ADVOCACY	7 (77.7)	4 (44.4)
EMPLOYMENT	6 (66.6)	5 (55.5)
HOUSING	6 (66.6)	3 (33.3)
FRIENDLY ASSURANCE-TELEPHONE	7 (77.7)	3 (33.3)
FRIENDLY ASSURANCE-VISITING	5 (55.5)	3 (33.3)
HOUSEKEEPING/HOMEMAKING	5 (55.5)	2 (22.2)
PERSONAL CARE	5 (55.5)	2 (22.2)
IN-HOME REGISTRY	3 (33.3)	1 (11.1)
COMPREHENSIVE ASSESSMENT	3 (33.3)	2 (22.2)
ADULT DAY HEALTH CARE	2 (22.2)	1 (11.1)

Both OAA and Non-OAA categories include direct providers and referrals.

American Indian organizations both provide direct service and refer individuals for services to other providers, irrespective of the funding source. Table 10 arrays the various types of services which centers offer. Social activities, identified as a need by urban elders (John, 1985) are now provided by two-thirds (66.7%) of the centers. Most centers provide information and referral (72.2%) as part of their service to the community and one center (5.5%) referred all elder issues to the local aging network. Advocacy for elders was available at half of the centers (55.5%) and legal aid was widely available through direct service (38.8%) or through referral (16.6%).

TABLE 10. SERVICES PROVIDED BY INDIAN CENTERS

SERVICE	DIRECT PROVIDERS	REFERRAL PROVIDERS[1]
	NUMBER (PERCENTAGES)	
CONGREGATE MEALS	10 (55.5)	1 (5.5)
MEALS ON WHEELS	5 (27.8)	2 (11.0)
TRANSPORTATION	11 (61.1)	0
SOCIAL	12 (66.7)	1 (5.5)
ACTIVITIES/ENTERTAINMENT	4 (22.2)	8 (44.4)
HEALTH CARE	4 (22.2)	6 (33.3)
HEALTH SCREENING	4 (22.2)	6 (33.3)
IN-HOME HEALTH SERVICES	4 (22.2)	5 (27.8)
CASE MANAGEMENT	4 (22.2)	2 (11.0)
INFORMATION & REFERRAL	13 (72.2)	1 (5.5)
LEGAL ASSISTANCE	7 (38.8)	3 (16.6)
ADVOCACY	10 (55.5)	1 (5.5)
EMPLOYMENT	9 (50.0)	2 (11.0)
HOUSING	8 (44.4)	1 (5.5)
FRIENDLY ASSURANCE-PHONE	9 (50.0)	1 (5.5)
FRIENDLY ASSURANCE-VISIT	7 (38.8)	1 (5.5)
HOUSEKEEPING/HOMEMAKING	5 (27.8)	2 (11.0)
PERSONAL CARE	5 (27.8)	2 (11.0)
IN-HOME REGISTRY	2 (11.0)	2 (11.0)
COMPREHENSIVE ASSESS.	3 (16.6)	2 (11.0)
ADULT DAY HEALTH CARE	-0-	3 (16.6)

[1] Referral sources included: Indian Center/Board - 7 (38.8%); Food Bank - 4 (22.2%); Aging Network -3 (16.6%); Legal Aid - 2 (11.0%)

Congregate meals were provided by more than half (55.5%) of the centers and only one center was able to refer elders to meal services. Participation in Meals On Wheels programs was more limited. Less than one third of the centers (27.8%) provided home delivered meals and only two centers (11%) provided referral. As a major node of information for the community, gaps exist in both nutritional services and referral for elders through the American Indian centers.

There is a tendency to refer health care issues to the local Indian Health clinics rather than to any other provider. However, 22.2% of the centers do provide health care, health screening, health education and in-home health services. Housekeeping/Homemaking and Personal Care were also available at 27.8% of the centers. Given the concerns of this older population over health care issues (Weibel-Orlando & Kramer, 1989) and the high levels of chronic disease experienced by older American Indians (NICOA, 1978), filling these gaps is crucial for urban American Indian elders.

The significance of case management techniques in assisting American Indians to receive comprehensive community-based long-term care has been demonstrated (Montana United Indian Assoc., 1974; NICOA, 1982; Weibel-Orlando & Kramer, 1989). However, only 22.2% of the American Indian centers offer case management. With considerable resources allocated to children, youth and family services, it is unlikely that social workers would have the expertise in geriatric evaluation and case management.

Certainly, there is a need to train American Indian professionals in that field. In addition, urban centers might leverage these services for elders by agreeing to refer and to collaborate with agencies funded to provide costly case management. Collaborative efforts might include mutual training workshops, sensitizing non-Indian staff to behaviors values and etiquette which orient American Indian elders' expectations, advocating and/or translating on behalf of elders, informing American Indian outreach and referral staff of eligibility criteria and procedures, technical advice and assistance to providing agencies, coordinating public and private services to support the elder, and interagency communication including case follow-up.

The impact of providing Older Americans Act services at urban American Indian multipurpose organizations is dramatically illustrated in Table 11. In most areas, the Indian centers are significant modes which attract a dispersed clientele. In Phoenix, for instance, the Indian center serves 48 (unduplicated) person, whereas the many generic centers serve no more than 2 elders. The average generic site serves American Indians in such small numbers that culturally sensitive programs targeting that population would be unrealistic.

While the urban American Indian centers may be significant focal points, they do not usually serve the majority of American Indians in any PSA. In Phoenix, for instance, 82 elders were served at generic senior citizen meal sites in contrast with the 48 persons served at The Indian Center. The exception is Denver, where meal service to elders is provided exclusively at The Denver Indian Center through a contract with Volunteers of America.

TABLE 11. INDIAN VS GENERIC PROVIDER SITES AVERAGE ATTENDANCE BY ELDERS.

CITY	Provider Averages: Title III(c)1 Services	
	American Indian Center	Generic Centers
Denver	138 (n=1)	0 (n=39)
Oklahoma City	71 (n=1)	10 (n=20)
Milwaukee	56 (n=1)	2 (n=41)
Phoenix	48 (n=1)	2 (n=39)
Tulsa	35 (n=1)	36 (n=27)
Alburquerque	30 (n=1)	3 (n=18)
San Francisco	25 (n=1)	17 (n=73)
Boston	19 (n=1)	17 (n=35)
Seattle[1]	***	***
Los Angeles[2]		17 (n=228)
Oakland		5 (n=51)
Chicago		4 (n=95)
Dallas		4 (n=14)
Portland		3 (n=2)
Minneapolis/St.Paul		2 (n=82)
Omaha		1 (n=34)
New York		>1 (n-102)
St. Louis[3]		0

*** Information not available or not reported by agencies.

[1] This data cannot be interpreted from MIS reports

[2] Los Angeles City and Los Angeles County PSA combined population reported in the 1980 Census.

[3] St. Louis served no American Indians in fiscal year 1989. Number of generic sites not requested.

Census data used for planning is shown in Table 12. The total population of persons 60+ is listed for each city. That total is broken down to show the number and percentage of American Indian elders age 60+ for each target city. The statistics are derived from the 1980

U.S. census. These figures are most certainly marred by the undercount of American Indians. Nevertheless, they serve as the basis for allocating resources. The percentages of American Indians in any of the cities is quite small in comparison to other population groups. Even in Los Angeles, which has the largest urban American Indian concentration in the U.S., American Indians comprise only 0.34% of the total population aged 60+.

TABLE 12.
AMERICAN INDIAN ELDERS REPORTED IN SELECTED CITIES IN 1980 CENSUS

CITIES	TOTAL ELDER POPULATION	AMERICAN INDIAN ELDER POPULATION (% OF TOTAL)
ALBUQUERQUE	49,487	728 (1.47%)
BOSTON	95,632	125 (0.13%)
CHICAGO	481,863	438 (0.09%)
DALLAS	174,304	348 (0.20%)
DENVER	181,967	392 (0.22%)
LOS ANGELES	1,055,208	3572 (0.34%)
MILWAUKEE	166,823	273 (0.16%)
MINNEAPOLIS/ST PAUL	260,934	680 (0.26%)
NEW YORK	1,296,965	1192 (0.09%)
OAKLAND	160,614	401 (0.25%)
OKLAHOMA CITY	99,949	1477 (1.48%)
OMAHA	61,636	103 (0.17%)
PHOENIX	243,170	1264 (0.52%)
PORTLAND	101,815	318 (0.31%)
SAN FRANCISCO	137,681	416 (0.30%)
SEATTLE	184,340	744 (0.40%)
ST. LOUIS	103,443	77 (0.07%)
TULSA	81,572	2955 (3.62%)

Source: Bureau of the Census (1983). 1980 Census of Population and Housing: Census Tracts, PCH80-2. Washington, D.C.: U.S. Government Printing Office.

Table 13 displays this MIS data reported for each of the 18 Planning and Service Areas surveyed. Data received on Title III(c) services reflect unduplicated counts. Inconsistent reporting patterns, however, are reflected in the data on Title III(b) which may include duplicated counts. For each service, the table shows the actual numbers of American Indians served in fiscal year 1989 and the percentage served of the total American Indian population age 60+.

TABLE 13. AMERICAN INDIAN ELDERS SERVED BY OLDER AMERICANS ACT TITLE III PROGRAMS IN SELECTED CITIES - FISCAL YEAR 1989[1]

CITY	TITLE III(b)	TITLE III(c)1	TITLE III(c)2
	(Percentage of American Indian Elders Served)		
ALBUQUERQUE	***	48 (6.59%)	0 (0.00%)
BOSTON	34 (27.20%)	55 (44.00%)	54 (43.20%)
CHICAGO	4 (.91%)	12 (2.74%)	4 (.91%)
DALLAS	62 (17.82%)	82 (17.82%)	***
DENVER	780 (****)[2]	138 (35.20%)	9 (2.30%)
LOS ANGELES	175 (4.90%)	730 (20.44%)	84 (2.35%)
MILWAUKEE	84 (30.77%)	84 (30.77%)	1 (.37%)
MINNEAPOLIS/ ST. PAUL	474 (69.71%)	82 (12.06%)	35 (5.15%)
NEW YORK	80 (6.71%)	48 (4.03%)	54 (4.53%)
OAKLAND	205 (51.12%)	249 (62.09%)	11 (2.74%)
OKLAHOMA CITY	759 (51.39%)	202 (13.68%)	86 (5.82%)
OMAHA	27 (26.21%)	26 (25.24%)	7 (6.80%)
PHOENIX	446 (35.28%)	96 (7.59%)	3 (.24%)
PORTLAND	73 (22.96%)	5 (1.57%)	0 (0.00%)
SAN FRANCISCO	357 (85.82%)	270 (64.90%)	16 (3.85%)
SEATTLE	***	416 (55.91%)	38 (5.11%)
ST. LOUIS	0 (0.00%)	0 (0.00%)	0 (0.00%)
TULSA	***	***	***

*** Information not available or not reported by agencies.

[1] Chicago - Fiscal Year 1990

[2] For Denver, Title III(b) participation as reported (780) is almost twice the American Indian Elder population reported in the 1980 Census.

In comparing Tables 12 and 13 few patterns emerge. The cities having the greatest proportion of American Indians age 60+ to the total elderly population doe not necessarily serve correspondingly large portions of the American Indian population. In Albuquerque and Oklahoma City, where American Indians represent more than 1% of the total elderly population, only 6.6% and 13.7% of their respective older American Indian populations receive Title III(c) services. On the other hand, a city such as Oakland, where older American Indians comprise 0.3% of the elderly population, 63% of all older American Indians receive congregate meals. In Los Angeles, where no urban Indian center is operating and no American Indian meal site has been designated, 20% of the elders received Title III services. Determining the underlying causes and policies for the apparently uneven distribution of resources was beyond the scope of this project.

One pattern does emerge which suggests that American Indians in the greatest economic need have not benefitted from Older Americans Act supportive services. Of the eighteen metropolitan Planning and Service Areas surveyed, nine did not provide Title III(c) services in proportion with that percentage of the American Indian population age 65+ who lived below the poverty level in 1979. This data is arrayed in Table 16. Again, it is not clear what circumstances and policies have contributed to this unequal distribution of services. However, it seems that American Indians in the greatest economic need are not being served in at least three midwestern, three western, three southern, and one northeastern city in our sample.

TABLE 14.

PERCENTAGE OF OLDER AMERICAN INDIANS LIVING IN POVERTY AND PERCENTAGE OF OLDER AMERICAN INDIANS SERVED BY TITLE III

U.S. REGION	% AMERICAN INDIANS 65+ BELOW POVERTY IN 1979[2]	% AMERICAN INDIANS 60+ SERVED BY PSA IN 1989[1]		AMERICAN INDIAN ELDERS IN PSA3
NORTHEAST	24.1	BOSTON	43.20	125 (0.13%)
		NEW YORK	4.53	1192 (0.09%)
MIDWEST	25.8	MILWAUKEE	30.77	273 (0.16%)
		OMAHA	25.24	103 (1.17%)
		CHICAGO	17.84	438 (0.09%)
		MINN./ST PAUL	12.06	680 (0.26%)
		ST. LOUIS	00.00	77 (0.07%)
SOUTH	28.8	DALLAS	17.82	348 (0.20%)
		OKLAHOMA CITY	13.68	1477 (1.48%)
		TULSA[4]	-----	2955 (3.62%)
WEST	20.6	SAN FRANCISCO	64.90	416 (0.30%)
		OAKLAND	62.09	401 (0.25%)
		SEATTLE	55.91	744 (0.40%)
		DENVER	35.20	392 (0.22%)
		LOS ANGELES[5]	20.44	3572 (0.34%)
		PHOENIX	7.59	1264 (0.52%)
		ALBUQUERQUE	6.59	728 (1.47%)
		PORTLAND	1.57	318 (0.31%)

[1] Based on unduplicated MIS reporting of Title III(c)1

[2] Source: Manson, S.M. (1988). Older American Indians: Status & Issues in Income, Housing, and Health. Presented at AARP Conference, Toward Empowering Minority Elderly. St. Louis.

[3] Source: Bureau of the Census (1983). 1980 Census of Population and Housing: Census Tracts, PCH80-2. Washington, D.C.:USGPO

[4] Data not available.

[5] Los Angeles County and City PSA's combined.

Table 14 compiles the differing types of data for analysis of targeting policy. Clearly, American Indians represent a small fraction, generally less than 1%, of the aged population in most areas. Satisfying targeting strategies to serve this small ethnic group to the extent of its proportion in the population may appear to equitably allocate limited resources in an economy of scale. However, this strategy fails to target those limited resources to American Indians in the greatest social and economic need.

IX. RESEARCH GAPS

METHODOLOGY

Diverse data bases were collected to assess the availability and access to support services funded through the Older Americans Act. The three major sources were: 1) a survey of American Indian organizations conducted by this project; 2) Management Information System (MIS) Reporting; and 3) U.S. Census Reports.

Library and archival research strategies were used to create the bibliographies on urban American Indian aging. This process was facilitated by on-line data bases. In addition, indices, shelves and archives were searched by project staff. Major sources of references for the bibliographies were the following libraries and data bases.

Libraries

- National Council on Aging library, Washington, D.C.
- Archives of final reports at the Administration on Aging, Washington, D.C.
- American Association of Retired Persons library, Washington, D.C.
- American Indian library collection at the Huntington Park Library, County of Los Angeles Public Libraries
- The libraries of the University of Southern California: Gerontology, Doheny, Van Kleinschmidt, Social Work, Seaver Science, Norris Medical, Government Documents

On-Line Data Bases

- On-line index of research and demonstration projects on older minorities and American Indians funded by the Administration on Aging and by the Office of Human Development Services
- Congressional Research Study requested through the office of Congressman E. Roybal (D-California)
- AARP Ageline
- Native American Research Information Service (NARIS), University of Oklahoma

- National Center on American Indian and Alaskan Native Mental Health Research, University of Colorado
- Public Affairs Information Service (PAIS)
- Government Document Catalog Service
- Congress Information Service - CD ROM
- Housing and Urban Development (HUD) User Data Base
- MASH Medlars-On-Line

National Resource Centers and Other Resources

- AARP National Gerontology Resource Center
- National Indian Council on Aging
- American Indian Studies Center, University of California at Los Angeles
- Office of Minority Health Resource Center, Public Health Service and American Indian Physicians Association
- National Center on Minority Aging Populations
- University Center on Aging, University of Massachusetts Medical Center, Minorities and Aging Bibliography
- Association for Gerontology in Higher Education, Brief Bibliography on American Indians

Materials related to urban American Indian aging were reviewed and abstracts prepared. The bibliographic annotations include citations to literature with a single passing reference, as well as to research that focuses exclusively on urban American Indian elderly. To the extent possible, the annotation includes major findings and supporting data.

The references and abstracts were arrayed on dBase to facilitate sorting and indexing. A maximum of five key words were assigned to each reference. Inclusion in the bibliography was determined by its content. Two criteria were used. The content must refer to 1) urban

American Indians and 2) older persons (including their needs, the process of aging, and socio-cultural roles, practices and beliefs).

As the reference search progressed, it became apparent that much of the literature did not specifically relate to aging. However, there is a body of literature which describes contemporary elders during an earlier period in their lives, particularly from 1960 - 1970. Therefore, selected references on this cohort's young adulthood experiences were also compiled as a second topical bibliography.

Various bibliographies on American Indian aging and on urban American Indians exist. Few titles, however, relate to urban American Indian aging. These bibliographies will be useful for comparative studies and for background on a wide range of issues. These sources were analyzed for their respective contents on urban American Indian aging and were compiled in a third topical bibliography.

FINDINGS

This project collected, codified and analyzed the literature on urban American Indian aging. The literature is reviewed on pages 12-37 of this report and compiled in the annotated bibliographies on pages 92-130. After extensive searches for published and unpublished sources, 97 references were identified that relate to urban American Indian aging. An additional 56 selected references are cited on urbanization and on aging of American Indians.

Interest in the aging of urban American Indians has increased dramatically since the 1960's. Both the range of topics and the number of issues addressed increased in each decade after 1960. The response shown in Figure 2 corresponds with the aging of this population who generally relocated to cities during the post World War II period.

Table 15 arrays the keywords found in the Bibliography on Urban American Indian Aging in descending order of the percentage of the literature devoted to each topic. Materials listed without dates were excluded from this list of 258 key words. Health, policy and social roles all received considerable attention in the past decade and these three topics account for 26% of the literature to date. The five most frequently addressed topics in the last decade were health, policy, social roles, service delivery and assessments. These topics had never been addressed during the period from 1960-1969. Nutrition, housing, life history, and social organization appeared as issues for the first time in the 1980's and only represent 3.6% of the total literature.

figure 2

TABLE 15. CONTENT ANALYSIS BY KEYWORD

KEYWORD	1960-69	1970-89	1980-90	TOTAL	% OF LITERATURE
HEALTH	0	9	19	28	10.9
POLICY	0	5	15	20	7.8
SOCIAL ROLE	0	5	14	19	7.4
SOCIAL SERVICES	0	6	12	18	7.0
MENTAL HEALTH	2	8	7	17	6.9
SOCIOECONOMICS	0	6	9	15	5.8
SERVICE DELIVERY	0	2	11	13	5.0
MIGRATION	2	3	7	12	4.6
MODEL PROGRAMS	1	3	6	10	3.9
ASSESS. OF NEEDS	0	3	7	10	3.9
DEMOGRAPHICS	0	4	6	10	3.9
OVERVIEW	1	1	5	9	3.5
SOCIOCULTURAL VALUES	0	3	3	9	3.5
RESIDENTIAL PATTERNS	1	3	4	9	3.5
SOCIOCULTURAL ADAPT.	1	4	5	8	3.1
SERVICE UTILIZATION	0	3	4	7	2.7
ETHNICITY	0	2	2	7	2.7
BARRIERS TO ACCESS	0	2	3	6	2.3
TRANSPORTATION	0	2	2	4	1.6
NUTRITION	0	1	1	4	1.6
AGE: DEFINED	1	1	2	4	1.6
LONG TERM CARE	0	2	1	3	1.2
RETIREMENT	0	1	2	3	1.2
EDUCATION	0	2	2	3	1.2
SOCIAL NETWORKS	1	1	2	4	1.0
HOUSING	0	0	0	2	0.8
LIFE HISTORY	0	0	1	2	0.8
EMPLOYMENT	0	1		1	0.4
SOCIAL ORGANIZATION	0	0		1	0.4
TOTALS	10	83	165	258	100.8%

Cuellar, Stanford, Miller-Soule (1982) analyzed the trends in minority aging from 1950 - 1980. Using their work as a benchmark, trends in the analysis of urban American Indian aging can be identified. Their methodology created twelve subject areas. Our key word were matched to their categories, lumping together key words such as employment and retirement and eliminating words such as model programs. The comparative subject analysis is shown in Table 16.

TABLE 16. SUBJECT ANALYSIS BY PERCENT OF THE LITERATURE

SUBJECT	AMERICAN INDIAN AGING (IN GENERAL) 1950-1980*	URBAN AMERICAN INDIAN AGING 1960-1990
HEALTH	11.8%	19.0%
PUBLIC POLICY/LEGAL/LEGIS.	55.6%	13.0%
TRANSPORTATION/MOBILITY**	-----	11.0%
MENTAL HEALTH	06.9%	11.3%
INCOME/ECONOMY	-----	10.0%
HOUSING/LIVING ARRANGE.	00.7%	07.0%
LITERATURE REVIEW/OVERVIEW	15.3%	06.0%
SOCIAL NETWORK/FAMILY RELAT.	06.9%	15.0%
EMPLOYMENT/RETIREMENT	00.7%	02.7%
EDUCATION	00.7%	02.0%
NUTRITION	-----	02.7%
LEISURE/RECREATION	01.4%	-----
TOTAL PERCENTAGE	99.9%	99.7%
TOTAL N =	143	150

* Extrapolated from Miller-Soule, D.I., Clair, J.M., Karafin, S.J. & Stanford, E.P., Minority aging research: The state of the literature, presented at the 34th annual meeting of the Gerontological Society of America, Toronto, as reprinted in Cuellar, Stanford, Miller-Soule, 1982.

** The categories of transportation and migration were included in this category.

The comparison of the two bibliographic subject analyses clarifies trends in the literature. The earlier bibliography focuses mainly on American Indians living on reservations. Health studies are significant to both populations. The differences in the populations under study is evident. While the legislative and policy debates continue, they seldom address issues relevant to older American Indians living off reservations. Much of the literature on urban elders discusses their relation to the reservations through either out-migration or reverse migration patterns. The surprisingly high percentage (15%) of studies on social networks and family relations reflects interest in adaptation of cultural values in a complex large-scale urban environment. The literature on urban older American Indians also addresses issues relevant to the urban poor in general: housing and living arrangements, employment and retirement, income and economics, and education.

As noted above, the range of subjects reflected in the annotated bibliographies compiled by this project is greater than previous studies. The lower percentage of sources devoted to literature reviews and overviews of urban American Indian aging (6.02% in the present study in contrast to 15.3%) is not an artefact of the wider range of topics covered. There are less than half the number of overviews on urban aging as compared to general overviews of American Indian aging. The distinctly fewer overviews of the literature on urban aging reflect the lack of attention currently given to this population.

Another useful comparison with Cuellar, Stanford and Miller -Soule (1982) is the source analysis (Table 17). The major source for literature on minority aging in general and for literature on urban American Indian aging are professional journals. The professional interest in urban American Indian aging, however, is not reflected in reports generated through proceedings of conferences or presentations. Important sources for information on urban American Indian aging have been in government documents, project reports and monographs by local American Indian organizations. Much of the literature remains difficult to obtain.

TABLE 17. COMPARATIVE SOURCE ANALYSIS

SOURCE	MINORITY AGING*		URBAN INDIAN AGING	
	N=	%	N=	%
JOURNAL ARTICLE	291	39.1	33	33.0
BOOK CHAPTER	58	7.8	16	16.0
GOVT. DOCUMENT	22	2.9	6	6.0
PROJECT REPORT	5	7.9	11	10.0
PROCEEDINGS	182	24.4	7	7.0
PRESENTATION	63	8.4	6	6.0
DISSERTATION/THESIS	8	1.0	1	1.0
UNPUBLISHED MANUSCRIPT	33	4.4	2	2.0
MAGAZINE/NEWSPAPER	12	1.6	7	7.0
BOOK/MONOGRAPH	15	2.0	14	11.0
TOTALS	743	99.5%	100	100%

* Source: Miller-Soule, D.I., Clair, J.M., & Stanford, E.P., (1981). Minority aging research: The state of the literature, presented at the 34th annual meetings of the Gerontological society of America, as presented in Cuellar, Stanford, Miller-Soule (1982).

Although there is increasing interest in a wide range of issues relevant to urban American Indian aging, the literature remains limited and researchers are given little exposure at professional conferences and annual meetings. The compilation of 100 sources include those having a single passing mention on older urban American Indians. While the content analysis indicated major areas of deficit, basic questions are unanswered in all categories.

The following section reports the literature in three annotated bibliographies: 1) Urban American Indian Aging; 2) Selected References on Experiences of Contemporary Urban American Indian Elders; and 3) Bibliographies on Urbanization and Aging of American Indians. A Key Word Index identifies references under topical areas.

KEY WORD INDEX

Aged: Defined

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Urban Indian centers are the primary providers of social services to American Indians. Access is enhanced by Indian staffing on site and the availability of culturally relevant casework services.

barriers, service utilization, social services

Ablon, J. (1964). Relocated American Indians in the San Francisco Bay Area: Social Interaction & Indian Identity. Human Organization 23, 296-304.

Ablon examines the influx of American Indians into metropolitan areas, creating a new urban ethnic group. In the early years of relocation, 3/4 of those who had relocated returned to reservations. The Indians about whom Ablon reports were 34 of the first 200 relocated. She notes that domestic problems, such as drinking and violence, do not appear to be peculiar to the rural-urban shift, but does state that most American Indians prefer to associate socially with other Indians. In fact, the social psychological imperatives of an Indian identity have a big impact on the comfort of becoming "urban." There are few aspirations for social mobility among Ablon's sample and she notes only superficial adjustments were made for living in a white world. Pan-Indian identity was a significant factor promoting successful accommodation to the urban environment.

migration, sociocultural adaptation

American Association of Retired Persons. (1988). A Portrait of Older Minorities.

This pamphlet synthesizes statistics generated from the 1980 U.S. Census. Significant features noted include: the proportion of elderly American Indians is growing faster than white or black populations; 96% of elderly Indians remain in households in the community and the oldest elderly are under-represented in the nursing home population; twice as many older American Indians are actively seeking employment, although American Indian elderly are employed at about the same rate as non-Indians; 25% of urban Indians live in poverty; and the life expectancy at 65 years is eight years less than that of the general population.

overview

American Indian Health Care Association (In Prep.). Assessment of the Availability and Quality of Services Provided to American Indian/Alaskan Native Elderly. St. Paul, MN: AIHCA

This report is forthcoming and was not reviewed, but it contains the results of a survey disseminated to Area Agencies on Aging in 1988 and a comparison of Title III and Title VI programs. A chapter describes the functional status of urban elders. In addition, there is a general profile of health status and health trends of elders.

American Indian Nurses Association (1978). Assessment of the availability and quality of services provided to American Indian/Alaskan Native elderly. National Conference on the Health of Elderly Indians. St. Paul, MN: AIHCA

The purpose of this report is to outline service areas that might be developed by tribal governments as Tribal Specific Comprehensive Health Plans, funded by P.L. 94-437.

health

Anonymous. (1984). Urban Indians Pose Unique Health Problems. American Medical News, September 28, pp 3, 19-20.

American Indians who leave their reservations lose Indian Health Service benefits after 120 days. The urban Indian Health Boards responded by providing alternate medical care that is culturally sensitive. The median age of deaths for Indians is 50, compared to that for whites, which is 75. Twenty-two percent (22%) of Indian deaths occur in infancy between the ages of 0-4 years. The major health problems are related to poverty and its consequences (e.g., poor nutrition).

health, socioeconomics

Anonymous. (1985). State and Local News. Aging Services News, October 10, pp. 142.

Citing Joan Weibel-Orlando, Ph.D., an anthropologist at the University of Southern California who has studied 200 American Indian families in southern California, about half can be expected to return to tribal homelands after retirement. Benefits of reverse migration are financial: less expensive housing, no sales taxes, and free social services. Special status is granted to elderly in Indian tribal culture.

ethnicity, migration, retirement

Anonymous (1985). Indians Migrate in Reverse. Talking Leaf 50(8).

This newspaper article cites Joan Weibel-Orlando on the phenomenon that even elders who had positive urban experience return to their reservations.

migration

Anonymous (1989). AoA Tallies Number of Indian Elders Participating in Titles III and VI. Older Americans Report 13(22).

Titles III and VI services to American Indians, in fiscal year 1987 in their respective provisions are compared. Of the 108,833 American Indians and Alaskan Natives eligible for Title III services, based on the 1980 Census, the actual participation in fiscal year 1987 was 39,506 in III-B supportive services; 29,458 in III-C1 congregate meals; and 7,997 in III-C2 home-delivered meals. Figures for Title VI, which may be duplicated counts, are also reported for fiscal year 1987. This report is based on an internal AoA document conducted under contracts with the

American Indian Health Care Association (ACKCO), Inc., National Indian Council on Aging, and the National Association of State Units on Aging.

demographics, service utilization

Association of American Indian Physicians, Inc. (1979). Physical and Mental Health of Elderly American Indians in the Continuum of Life: Health Concerns of the Indian Elderly. 2nd National Indian Conference on Aging. Billings, MT, August.

A review of the 1970 U.S. Census data, demography, case studies, and history of migration from reservations to urban centers. Recommendations are made for improvement of health and mental health services in urban areas. Recommendations also are made for research on health and mental health characteristics and needs.

health, demographics, mental health

Attneave, C.L. (1969). Therapy in Tribal Settings and Urban Network Intervention. Family Process 8(2), pp. 192-210.

This article examines network interaction among Indian families in non-urban settings as ways to resolve depression, child placement issues, etc. The therapist may act as a social engineer to

create networks that approximate the therapeutic characteristics of tribal network-clans. The role of elders in these networks is incidentally elucidated.

mental health, model programs, social networks

Baker, F.M., Kamikara, L.M., Espino, D.S., Manson, S.M. (no date). Rehabilitation in Ethnic Minority Elderly. 41 pages.

Demographics of rural and urban American Indian elderly are compared. The discussion focuses on the need to understand the cultural concepts and beliefs regarding disease, illness, and treatment in order to develop rehabilitation strategies.

demographics, health, rehabilitation, sociocultural values

Bell, D., Kasschau, P., Zellman, G. (1976). Delivering Services to Elderly Members of Minority Groups: A Critical Review of the Literature. Santa Monica, CA: RAND.

American Indians are more effectively denied access to support programs than any other ethnic minority group. Although urban American Indians are denied services by the Bureau of Indian Affairs (BIA), local providers do not accept a responsibility which is lodged with the BIA for other Indians. Reservation-city movements provide city and county welfare agencies with rationales that those in need do indeed return to reservations for services. While federal policies encourage relocation and assimilation in cities, current policies denying them access to services available to other Americans frustrates federal goals and forces individuals to return to reservations.

policy, service delivery

Bell, D., Zellman, G. (1976). Issues in Service Delivery to Ethnic Elderly. Rand Paper Series. Santa Monica, CA: RAND.

The history of the relationship between federal agencies and federal policy toward Indians is reviewed. Unmet needs and barriers to accessing services are noted. Differences in the problems of urban and reservation Indians are stated, but the policy recommendations are similar. American Indians should be given control of designing programs that provide service delivery mechanisms to fill the "overwhelming" magnitude of unmet needs, given the current level of service utilization.

policy, service delivery, service utilization

Betts, N.M., Crase, C. (1986). Nutrient Intake of Urban Elderly American Indians. Journal of Nutrition for the Elderly 5(4), 11-18.

Comparison of a three-day dietary record of 20 American Indian and twenty non-Indian elderly living in Lincoln, Nebraska. Results show that nutrient intake of elderly American Indians, the majority of whom were below the poverty line, was similar to that of the general elderly population. In both groups, total food energy, vitamin A, and calcium were below the recommended levels. In contrast to older American Indians living on reservations, no extensive nutritional inadequacies were reported.

nutrition

Block, M.R. (1979). Exiled Americans: The Plight of Indian Aged in the United States. In D.E. Gelfand & A.V. Kutzek (eds.), Ethnicity and Aging: Theory, Research and Policy. New York, NY: Springer Publishing Company.

Attention is focused on issues and policies affecting older American Indians; two specific references are made to off-reservation elderly. Block asserts that as younger American Indians leave reservations and are assimilated into urban settings that the number of elderly living on reservations will decrease. Elderly who live off-reservation and require in-home services need formal assistance because the financial burden is beyond the means of either a pension or an extended family income.

health, policy, residential patterns, social roles

Cain, L.D., Manson, S.M. (1989). Ethnicity and Aging: A Study in Creative Adaptation. Medical Anthropology.

This article reports a study of when and how urban black and American Indian elderly mobilize their respective support networks, formal and informal, when facing problematic life situations.

Three measurement instruments are used to interview 90 members of each subject group. The analysis explores similarities and differences in perceptions of problematic situations and compares patterns of support between and within the two elderly samples.

ethnicity, social networks, social services, sociocultural adaptation

Citron, A. (1988). Aging Indians Finding They can go Home Again. *Los Angeles Times*, March 6, pp. 1, 34, 36.

Citron cites Weibel-Orlando that Indians return to their reservations for free hospitalization, federal housing subsidies, food allowances, etc. The people described have adapted to 20-30 years of urban life, but have not lost their ethnic identity, which is associated with their tribal homeland. Referring to Weibel-Orlando's study, 24 of 40 (60%) of older American Indians returned to their reservations.

ethnicity, migration

City of Anchorage. (1974). City of Anchorage Demonstration Transportation Grant. Washington, D.C.: Urban Mass Transportation Administration, 101 pp.

This demonstration project attempted to develop a transportation route that served previously limited access areas in Anchorage, Alaska. Although the affected area included elderly American Indians and Alaskan Natives, their particular response to improved transportation was not singled out for evaluation.

transportation

Cooley, R.C., Ostendorf, D., Bickerton, D. (1979). Outreach Services for Elderly Native Americans. *Social Work* *24*(2), 151-153.

Apache elders needing long-term care are placed in nursing homes in Phoenix, Arizona. The Apache Tribal Guidance Center provides a link to those elders housed off reservations through a program of visits, social events, mental health counselor visits, advocacy, native foods, and news delivered in the Apache language. The program, in its seventh year, bridges cultural gaps in an inexpensive and simple manner.

long-term care, model programs

Curley, L. (1978). Retirement: An Indian Perspective, In E.P. Stanford (ed.) *Retirement: Concepts and Realities*, Proceedings of the 5th National Institute on Minority Aging. San Diego: Center for Aging, SDSU.

Consideration is given to retirement on reservations. The current elders need no retirement planning. However, middle-aged employed American Indians would need planning and reorientation to adjust to life on the reservation after working.

retirement

Curley, L. (1982). Indian Elders: A Failure of Aging Policy. Generations , pp. 22, 52.

This article poses the question: Do the Older American Act policy and services detract rather than support the traditional American Indian social roles and intergenerational commitments? No reference is made to any distinction between urban or reservation American Indian circumstances, values, or cultural differences.

policy, sociocultural values

Daines, G.M.G. (1980). American Indian Elderly: Needs Assessment and Student Training Model. DSW Dissertation. 119 pp. University of Utah/DAI Order #8022206.

This dissertation studied a tentative framework for training social workers to serve elderly American Indians. Daines sought information about agency and service providers, characteristics of their clientele, methods used, and services offered. Recommendations are made concerning use of the framework and implementation of service programs for American Indian elderly.

assessment, model programs, policy, service delivery

Dukepoo, F.C. (1975). Cochise in a Centrifuge: A Brief Analysis. In E.P. Stanford (ed.), Minority Aging, Second Institute on Minority Aging Proceedings (pp. 12-16). San Diego: Center on Aging, SDSU.

The paucity of information on elderly American Indians requires that comments be made on the general characteristics of American Indians. Specific comments on elderly are made about the low self-esteem of men over the age of 30 and the vital need for transportation. Specific comments on urban American Indians commend conference participants to work with and through urban Indian organizations.

health, policy, socioeconomics, sociocultural values, transportation

Dukepoo, F.C. (1980). The Elder American Indian. San Diego: Campanile Press, SDSU.

Interviews and assessments were conducted with 62 older American Indians, aged 54-92 years, living in the San Diego area. Twenty-eight elders resided in urban rather than in reservation settings. Eighty percent of the urban elders were committed to staying in the city, but sixty-eight percent would relocate to reservations if opportunities existed there. In comparison to the 34 reservation dwelling elders, the urban population was younger (mean age 65.5 years), had greater numbers of married and divorced individuals than widows, had a higher annual income ($5,880), a lower unemployment rate (57%), a greater number of years of education (an average 8.7 years), greater attendance at public schools (64%) rather than BIA schools, shorter residency in San Diego County (63.3 years), as well as in their respective neighborhoods (38.5 years). In addition, the urban elders used medical facilities less frequently, had less contact with family members, made greater use of formal services, and had less difficulty in completing application forms. Barriers to accessing medical care and to using formal services were felt more acutely by urban elders. These barriers included fear, mistrust, cultural insensitivity, inconvenience, and the lack of financial resources. Unlike reservation elders who wanted a food program to fill their nutrition needs, the urban elders wanted better quality food, more food, and a social context for meals.

residential patterns, social services, sociocultural values, socioeconomics

Eck, Roger D., St. Louis, R. (1972). Research Results Concerning the Economic and Social Problems of Elderly Urban Indians in Phoenix. 95 pp. Phoenix, AZ: LEAP.

This article presents research results from 144 comprehensive questionnaires completed by American Indians, age 55-75, living in Phoenix, Arizona. This project (partially supported by DHEW Grant aa-4-70-063-03) presents statistically significant results, but does not evaluate services, nor make recommendations based on the findings.

health, social roles, social services, socioeconomics

Edwards, E.D. (1983). Native-American Elders: Current Issues and Social Policy Implications. In R.L. McNeely & J.N. Colen (eds.), Aging in Minority Groups (pp. 74-82). Beverly Hills, CA: Sage.

This general overview of Indian aging is presented with reference to reservation-based elderly. With respect to urban elderly, Edwards et al. state that, "data reflecting needs ...are almost non-existent." Citing the National Indian Council on Aging, needs of urban Indian elderly relate to loneliness and depression.

overview

Edwards, E.D., Edwards, M.E., Daines, G.M. (1980). American Indian/Alaskan Native Elderly: A Current and Vital Concern. Journal of Gerontological Social Work 2(3), 213-224.

Questionnaires were distributed to 288 agencies serving older American Indians and Native Alaskans. Of the 157 respondents, 28% were located in urban areas. It is not possible to disaggregate urban vs. reservation/rural responses from the tables in this article. Findings include: 1) identification of American Indians, aged 50-80+ years receiving services; 2) the majority of agencies (n=116) served American Indians 80+ years; 3) direct services were insufficient to meet the existing needs; 4) the gaps in services were greatest in the areas of homemaker services and nursing homes; 5) services were generally provided by paraprofessionals; and 6) there is a need to professionally train American Indian social workers to staff elderly programs.

assessment, model programs, service delivery

Essandoh, R. (1977). Major Concerns of the Elderly Native Americans. In B.L. Newsome (ed.), Insights on the Minority Elderly - Part II, (pp. 26-28). Washington, D.C.: National Caucus and Center on Black Aged. Institute of Gerontology, UoDC.

This essay is part of a symposium on elderly minorities. Essandoh begins by recognizing the three geographic areas where aged American Indians reside: urban, rural, reservation. She addresses areas of particular concern when discussing the needs the elderly American Indians: old-age benefits, housing, income, health, nutrition, and transportation. In conclusion, Essandoh writes that older American Indians, as well as all poor older people, need strong advocacy to insure that issues important to their lives are discussed and that they have some input in decision-making.

overview

Feldman, K.D., Hines, C. (1979). Demographic and Adaptational Characteristics of Elderly Alaskan Natives in Anchorage, Alaska. National Sciences Foundation. Norman, OK: NARIS, University of Oklahoma. 24 pp.

This descriptive study focuses on the demographic characteristics and life satisfaction attitudes of older Alaskan natives (55+), residing in Anchorage, Alaska. For this research, 85 persons were sampled and were found to be better educated than their rural counterparts, non-rural in background, relatively poor, and comparative non-users of social services. Nevertheless, these respondents were relatively satisfied with their lives and felt that they were better off than other elderly people.

demographics, education, mental health, service utilization

Gillum, R.F., Gillum, B.S., Smith, N. (1984). Cardiovascular Risk Factors Among Urban American Indians: Blood Pressure, Serum Lipids, Smoking, Diabetes, Health Knowledge, and Behavior. American Heart Journal, 765-766.

Cardiovascular risk factors were assessed for American Indians living in the Minneapolis area, aged 16-84 years. High risk for heart disease and stoke was found and the finding is consistent with the extremely high prevalence of diabetes, cigarette smoking, obesity and the moderately elevated blood pressure and serum cholesterol levels discovered. Approximately 10% of the sample was age 55+.

health, nutrition

Guillemin, J. (1975). Urban Renegades: The Cultural Strategies of American Indians. New York,NY: Columbia University Press.

Micmac elders living in Boston rather than on Canadian reservations are mentioned in two contexts. The older, less mobile and health impaired Micmac who live in the economically depressed South End of Boston are less actively involved in the tribal social network which shares resources. Instead, they are more dependent on public social services for assistance. Throughout the text, elders living in extended family settings in Boston are incidentally described as household members. Micmac in their late 40's appear to be old, as a result of poverty and physically demanding jobs.

health, migration, social services, sociocultural adaptation, socioeconomics

Hackett, G., Reese, M., Harlan, B. (1988). Back to the Reservation. Newsweek, May 3, pp. 28.

Citing Joan Weibel-Orlando, anthropologist at the University of Southern California, this article reports that a growing number of American Indians are returning to their tribal reservations after retirement because the Bureau of Indian Affairs provides food, housing, and hospitalization to ease the financial burden of elderly urban Indians living on limited incomes. The authors apparently misunderstood the role of the BIA.

ethnicity, migration, retirement, socioeconomics

Hanson, W. (1980). The Urban Indian Woman and her Family. Social Casework 61(8), 476-483.

The increasing participation roles for urban American Indian women is attributed to their differential entry in the labor force in comparison to their husbands, who are hampered by ethnic discrimination and limited job opportunities. Examples are offered of five women, aged 35-65 years, who successfully adapted to an urban context without the support of the extended family.

social roles, sociocultural adaptation

Hendricks, J., Hendricks, C.D. (1986). Aging in Mass Society, Volume 3. Cambridge, MA: Winthrop.

Noting the findings of the White House Conference on Aging, 1981, urban elders are described as those who "also suffer from the lack of facilities designed to provide care for those without health insurance and who have insufficient incomes to pay for health care."

overview

Hill, G. (1988). Response: Projected Patterns of Health and Functional Dependency, Urban American Indian Elders. ASA Meeting, 1988.

Extensive needs assessment of 550 American Indians of all ages, living in the San Francisco-Oakland area was conducted. The elders are dispersed and there is an existing infrastructure of American Indian organizations that provides opportunities for interaction, especially with elders.

assessment, demographics, health, social services

John, R. (1985). Service Needs and Support Networks of Elderly Native Americans: Family, Friends and Social Service Agencies. In W.A. Peterson, J. Quadagno (eds.), Social Bonds in Later Life: Aging and Interdependence, (pp. 229-247).

This is a comparison of urban and rural responses to the NICOA 1981 study on American Indian elders age 45+. Particular emphasis is placed on the role of the extended family in contemporary American Indian societies and the extended family as potential or actual providers of support services.

demographics, social roles, social services

John, R. (1986). Social Policy & Planning for Aging American Indians: Provision of Services by Formal and Informal Support Networks. In J.R. Joe (ed.), American Indian Policy & Cultural Values, (pp. 111-133). UCLA: American Indian Study Center.

This essay focuses on the issue of service utilization by American Indian elders. John points to three reasons that have been offered for the limited use of services by minority groups: availability, awareness, and accessibility. Ironically, the ten services most needed do not happen to be the same ten that are most available. Low service utilization is often attributed to fear and mistrust of non-Indian providers, as well as to the cultural insensitivity of these service providers. John compares urban and reservation Indians over the age of forty-five. Approximately half of all American Indians live in urban areas, but it is unclear whether the same proportions apply to Indian elders. Urban Indians show higher service utilization rates for formal social services, while reservation Indians rely more on informal services.

policy, service utilization, social networks, social roles, social services

John, R. (1988). The Native American Family. In C.H. Mindel, R.W. Habenstein, R. Wright, Jr. (eds.), Ethnic Families in America: Patterns and Variations, 3rd Edition (pp. 325-363). New York: Elsevier.

Substantially greater need for health and support services are found among reservation elderly than among urban Indian elderly. Both reservation and urban elders' primary Assessment of Daily Living (ADL) needs are with housework, transportation, using telephones, and shopping. Urban elderly are less likely to rely on family members as the only providers of direct service. Family networks are significant to both urban and reservation communities. A review of the literature critiques notions concerning the American Indian family and defines areas for research.

health, social roles, social services

Joos, S.K., Ewart, S.· (1988). A Health Survey of Klamath Indian Elderly 30 Years After the Loss of Tribal Status. Public Health Reports 103(2), 166-173.

A modified OARS instrument was used to survey 202 Klamath, age 40+, of whom: 55% lived in the former reservation area; 15% lived in the nearby city of Klamath Falls; 32% lived in the cities of Portland, Salem, and Eugene; and 12% lived in other locations. Although a younger population, their health status was similar to that of other American Indian populations and worse than that of non-Indians. Slight socioeconomic differences between reservation and urban elders are noted. One-third of those 65+ years preferred living independently from extended families.

health, mental health, residential patterns, socioeconomics

Kaplan, H., Taylor, B.J. (1972). Economic and Social Problems of the Elderly Urban Indian in Phoenix, Arizona. Administration on Aging, HEW, Washington, D.C. Phoenix, AZ: LEAP Project. 99 pp.

This report addresses four topics: the socioeconomic problems of the elderly urban American Indian in Phoenix, Arizona (N=150); the research purpose and method of this study; the results of

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an in-depth survey of 144 American Indians in Phoenix, Arizona (1972); and the results of a nutritional survey.

nutrition, policy, social services, socioeconomics

Kivlahan, D.R., Walker, R.D., Donovan, D.M., Mischke, H.D. (1985). Detoxification Recidivism Among Urban American Indian Alcoholics. American Journal of Psychiatry 142(12), 1467-1470.

In a sample of 50 American Indian patients admitted to Kings County Detoxification Center over a two year period, there was no improvement as operationalized by Westermeyer and Peake (1983) as two years of total abstinence and no further use of detoxification or other inpatient facilities for the past year. The mean age was 41.0 years (SD = 9.6 years). Three individuals reporting 6 months abstinence periods were 51, 52, and 64 years respectively and vignettes are provided about their life conditions and reasons for abstinence.

health, mental health

Klunder, J. (1983). Indians Live Here but Their Hearts are Back Home. Los Angeles Times, May 26.

Vignettes of elders in Los Angeles who miss their birth place and want it to be their final resting place, although their children and grandchildren plan to stay in Los Angeles.

migration, residential patterns

Kramer, B.J., Hyde, J. (In Preparation). Urban American Indian Elderly: A Little-Known, Stable Population in Los Angeles.

A re-examination of the database of the Urban American Indian Elders Outreach Project to refine analysis of need and age. Significant impairments in some Activities of Daily Living were found for those 60+. Policy and service delivery strategies are recommended.

assessment, health, policy, service delivery

Kramer, B.J. (1990). The Urban American Indian Elders Outreach Project. Paper presented at the Annual meeting of the American Society on Aging. San Francisco, April 1990.

Findings of the Urban American Indian Elders Outreach Project (Weibel-Orlando, J., Kramer, B.J. et al., 1989) are expanded and re-examined in relation to impairments in Activities of Daily Living (ADL) and family roles in providing supportive services.

assessment, health, service delivery

Kramer, B.J. (In Press). The American Indian Elder in Los Angeles. Aging.

A report of outreach strategies to older American Indians living in Los Angeles and an evaluation of linkage activities conducted as a demonstration project of the Administration on Aging.

service delivery

LaFromboise, T.D. (1988). American Indian Mental Health Policy. American Psychologist 43(5), 388-397.

This article looks at the role of elders in personal and religious counseling, which has been incorporated into an "elders" movement (i.e., a social network that solicits this traditional role from elders).

mental health, social roles

Larsen, D. (1989). The Invisible Minority. Los Angeles Times, October 8, 1988.

Larsen notes that there are no American Indian neighborhoods in Los Angeles County, the importance of the extended family, and the need for an American Indian senior center to coalesce services targeting older American Indians. The general public's lack of awareness of the large Indian population in Los Angeles and inability to identify Indians creates an "invisible minority."

barriers, ethnicity, residential patterns, social roles

Liebow, E.B. (1983). A New Chapter: Elderly Urban Indians & Political Activism in Phoenix. Paper presented at 82nd Meeting of the American Anthropological Association, Chicago, Illinois.

Liebow analyzes 22 life history interviews with 16 women and 6 men, aged 60-81, who live in Phoenix, Arizona. For many of those interviewed, senior centers provide a sociable arena for engaging in issues relevant to an aging population, such as health care, transportation, and stress management. According to Liebow's findings, the aging process is characterized by elderly urban American Indians from a metropolitan area (Phoenix) as increasing pragmatism, stability, and the potential for greater interest and participation in political activities.

health, life history, social network, social organization, transportation

Locust-Pettit, Poppy M. (1979). Needs Assessment in Minority Aging Research. In E.P. Stanford (eds.), Minority Aging Research: Old Issues, New Approaches (pp. 79-88). San Diego, CA: SDSU.

As part of a conference on minority aging research, this essay presents an overview of needs assessment for American Indian elderly in general. Of particular importance are four basic questions: 1) the needs of American Indian elderly; 2) the type and degree of need by age cohort among Indians 45+ as compared to a non-Indian population aged 60+; 3) the currently available services; and 4) the adaptations needed in providing services to insure that the needs of the elderly Indian are met. The author states that the single most important barrier to realization of the Older Americans Act is cultural ethnocentrism. The lack of information about older American Indians is a major gap in the literature on minorities.

assessment, barriers, social services

Lustig, J., Ross, A., Davis, D., Old Elk, J. (1979). The Needs of Elderly Indians in Phoenix, Arizona: Recommendations for Services. Affiliation of Arizona Indian Centers, Inc. 110 pp.

This study provides services and planning agencies with information about the needs and services of elderly Indians in Phoenix. In depth interviews were conducted with senior citizens in their homes, nursing homes, or multipurpose senior centers, as well as with administrators and staff of American Indian senior programs. Findings indicate that the elderly maintain close contact with Indians and Indian organizations, particularly with those from Arizona. The isolation of American Indians in cities comes from the lack of ties, culture, language and unfamiliarity with available social services. American Indians in nursing homes are particularly deprived, as are other urban Indians not entitled to reservation services. Recommendations urge the linkage of Indian Centers, Indian Advisory Committees, and churches to provide services and advocacy for urban Indians.

assessment, health, social networks, social services

Lyon, J.P. (1978). The Indian Elder, A Forgotten American. Final report of the First National Indian Conference on Aging, Phoenix, Arizona, June 15-17, 1976. 595 pp. Washington D.C.: National Tribal Chairmen's Association.

Proceedings of the first National Indian Conference on Aging, 1976, are reported. Testimony concerning needs assessments, program development recommendations, responses to needs from federal agencies and demographic reports from specific reservations and urban Indian organizations. In response to a needs assessment of participants, the three most frequently cited needs of urban Indian elderly are transportation, legal aid, and health services. The report includes discussions of needs and program recommendations for the urban Indian elderly living in Boston and in Phoenix. Arguments are presented for need versus age considerations in developing programs for American Indian elderly in order to reflect their lower life expectancy.

assessment, health, model programs

Manson, S.M. (1988). Older American Indians: Status and Issues in Income, Housing and Health. Paper prepared for the American Association of Retired Persons Conference "Toward Empowering Minority Elderly," September 8-9, 1988.

An overview of the findings of the 1970 and 1980 U.S. Census relating to American Indians, with an emphasis on the regional differences between rural and urban American Indian elderly populations. A number of research questions are raised, such as, has the epidemiological transition occurred and what are its implications for health services?

demographics, health, housing, socioeconomics

Manson, S.M., Murray, C.B., Cain, L.D. (1981). Ethnicity, Aging and Support Networks: An Evolving Methodological Strategy. Journal of Minority Aging 6(1&2), 11-37.

Manson, et. al. provide a review of the literature on black and Indian elderly in their study of how minority urban elderly (10 blacks, 10 Indians in Portland, OR) over the age of 55 deal with problematic life situations. The authors study the degree to which older persons call upon informal support networks for help. They suggest a methodological strategy to provide a comparative framework for understanding similarities and differences within and between ethnic minorities in how older members resolve problematic situations.

overview

Manson, S.M., Pambrun, A.M. (1979). Social and Psychological Status of the American Indian Elderly: Past Research, Current Advocacy and Future Inquiry. White Cloud Journal 1(3), 18-25.

Literature reviewed is found to be limited in size, scope and relevance to current issues affecting American Indian elderly. A survey of participants in the 2nd NICOA meeting indicates differences between urban and reservation elderly with respect to life satisfaction, satisfaction with available support services, and transportation.

mental health, residential patterns, social services, sociocultural adaptation

Manuel, R.C. (ed.) (1982). Minority Aging: Sociological and Social Psychological Issues. Westport, CT: Greenwood Press.

In the summary chapters of this book, occasional references are made to issues or literature referring to American Indians. Nevertheless, the substantive papers relate to other minorities.

The dearth of literature on American Indians is indicated by the identification of only four studies by the Council of Planning Librarians in 1975.

overview

Martin, H.W. (1964). Correlates of Adjustment Among American Indians in an Urban Environment. Human Organization 23(4), 290-299.

Adjustment to urban life correlates negatively with age. "Older" American Indians are aged 25-30 years.

aged: defined, migration

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Meister, C.W. (1978). The Misleading Nature of Data in the Bureau of the Census Subject Report on the 1970 American Indian Population. The Indian Historian 11(4), 12-19.

The 1970 report is based on sampling data rather than on the available complete count data. Because small populations were the basis of the sample, the error factor is enormous.

demographics

Montana United Indian Association (1976). Final Report, Montana United Indian Association, Elderly Urban Indian Project.

Based on the life condition of older American Indians, the Montana State Office of Aging sought and was granted permission to lower the age of eligibility for Older Americans Act services to 45 years. A limited senior program was developed and implemented based on a needs assessment. The successful program outcomes were a result of advocacy on behalf of Indian elders. The project recommends that service providers utilize their model of peer advocates who are knowledgeable about the aging network and able to negotiate in the larger white community for the benefit of the older American Indian.

assessment, model programs

Murdock, S., Schwartz, D., Hwang, S. (1980). The Effects of Socioeconomic Characteristics and Off-Reservation Contacts on the Service Awareness and Wage Patterns of Elderly Native Americans. Long-Term Care and Health Services Administration Quarterly Vol. 4.

This article has not been reviewed, but we wanted to include it for the information it might provide about the relationship between socioeconomic characteristics and off-reservation contacts on service awareness and wage patterns of elderly American Indians.

service utilization, social services, socioeconomics

National Aging Resource Center on Elder Abuse. (1989). American Indian Elder Abuse: Exploring the Problem. Washington, D.C.: NARCEA.

Proceedings are reported from a National Meeting of American Indians on elder abuse, both on and off reservations. Urban elders tend to be served by a state unit of adult protective services which is not attuned to the needs of older American Indians. Recommendations are made for federal legislation, including an older Indian Bill of Rights which would stipulate procedures that would best serve older American Indians.

policy, sociocultural values

National Indian Council on Aging, Inc. (1979). The Continuum of Life: Health Concerns of the Indian Elderly, Final Report, 2nd National Indian Conference on Aging, Billings, MT. Albuquerque, NM: NICOA. 205 pp.

Reports on resolutions and recommendations of the 2nd National Indian Conference on Aging which was attended by representatives from 209 separate tribes, 42% living in urban areas. Throughout the report specific needs of urban elderly are identified. Recommendations are made, designing urban health programs for Indian elderly.

demographics, health, long-term care, mental health

National Indian Council on Aging, Inc. (1980). The National Indian Council on Aging: The First 3 Years of a National Indian Task Force Operation. Albuquerque, NM: NICOA.

This report presents an overview of Indians of North America, including problems and solutions. The federal response to unmet needs is detailed for reservations and for the following urban areas: Denver, Minneapolis, Pittsburg, Tulsa, and Tacoma.

policy, service delivery

National Indian Council on Aging, Inc. (1981). American Indian Elderly: A National Profile. Albuquerque, NM: NICOA.

A sample of 712 responses to a modified OARS instrument was collected from American Indians and Alaskan Natives, aged 45+, living in urban and rural settings nationwide. Although the number of responses from urban elders is not clearly indicated, the articulated strategy was to produce a 25% sample from urban areas. The urban-rural data is not diseggregated in the tables presented in the index. The analysis found that reservation elders are 45+ and urban elders age 55+ had characteristics similar to those of the general population at age 65+. Policy recommendations are made.

health, mental health, socioeconomics, transportation

National Indian Council on Aging, Inc. (1981). Indian Elderly and Entitlement Programs: An Accessing Demonstration Project. Albuquerque, NM: NICOA.

This report details model programs, part of a project to improve by 100% access to entitlement programs on four reservation sites. Urban American Indian elderly are not included in the demonstration project. However, urban elders are described in the introduction as comprising 48% of the 109,000 American Indians age 60+, and as unlikely to receive health or dental care. Routine and preventive health care for urban elderly is generally unavailable because: 1) they are not served by Indian Health Services (IHS); and 2) public agencies operate under the misconception that either IHS or the Bureau of Indian Affairs (BIA) will care for them.

demographics, health, model programs, service delivery, sociocultural values

National Indian Council on Aging, Inc. (1982). Access: A Demonstration Project, Final Report. Albuquerque, NM: NICOA.

This report expands access to entitlement programs to include urban areas by adding a pilot site in Albuquerque, NM. A needs assessment of 120 of 600 American Indian elders in Albuquerque found physical, psychological, and logistical barriers to access services with no assistance from the model program. Other barriers targeted the lack of information about entitlement programs and application procedures, transportation, telephones or inability to hear well on phones, contact with entitlement outreach staff, and fear of entitlement staff. Recommendations include assessment priorities, methods to address needs, and model work plans to implement access models in other locations.

assessment, barriers, model programs, service delivery

National Indian Council on Aging, Inc. (1983). Indian Elders: A Tribute. Proceedings of the 4th National Indian Conference on Aging, Reno, Nevada, August 23-25. Albuquerque, NM: NICOA.

These proceedings explore the importance of considering "special circumstances and sometimes intensified needs" of urban elderly when formulating policy and programs. The proceedings affirm the need to recognize the unique relationship between the reservation and the federal government.

policy

Presbyterian Church (USA). (1988). American Indian Community Survey. American Indian Research Center, Huntington Park Library. 3 pages.

Results of the 1987-88 survey, which does not include an age-breakdown, records length of time living in Los Angeles: 0-1 year (16%); 1-5 years (12%); 6-10 years (8%); 11-20 years (22%), 20+ years (41%).

residential patterns

Price, J. (1981). North American Indian Families. In C.H. Mindel and R. W. Haberstein (eds.), Ethnic Families in America: Patterns and Variations, 2nd Edition. New York: Elsevier.

In this chapter, the Los Angeles American Indian Community is compared with three rural or reservation communities. Considerable shifts away from traditional marriage, social, and religious practices were found. Reservation attitudes about spending money were retained and large portions of household budgets went to travel and entertainment. Most urban Indians "commute" to home reservations, but some finally settle permanently in Los Angeles and create a Pan-Indian culture. There are over 100 tribes in Los Angeles. There is a tendency to idealize reservations, even talk about retiring there, as social contacts and visits to reservations decrease over time.

migration, social roles, sociocultural adaptations, socioeconomics

Red Horse, J.G. (1980). Family Structure and Value Orientation in American Indians. Social Casework 61(8), 462-467.

This article traces the historical emphasis on the American Indian extended family and the importance of the extended family structure. The extended family is purported to be maintained in small reservation communities, interstate residential arrangements, medium urban areas, and metropolitan centers.

social roles

Red Horse, J.G. (1980). American Indian Elders: Unifiers of Families. Social Casework, October, pp. 491-493.

Among American Indian families the responsibilities of elders increase with age. Family life is inseparable from religious life with traditional families. Cultural values, traditions, and spiritual values are transmitted through the elders. By maintaining culturally appropriate roles, elders may not readily accept programs designed for Anglo families. A successful foster grandparent program in Minneapolis is cited as an example of a service which benefits from the American Indian tradition and integrating generations. An unsuccessful congregate meal program in Minnesota is cited as an example of a service that fails to recognize the cultural implications of intergenerational isolation.

social roles

Red Horse, J.G. (1981). American Indian Elders: Needs and Aspirations in Institutional and Home Health Care. In E.P. Stanford (ed.), Minority Aging: Policy Issues for the 80's. Proceedings of the 7th Institute on Minority Aging.

Recommendations are made to establish governing boards that reflect the tribal constituency and who then set the direction and policy of support services targeted for American Indian elderly.

policy, social services

Red Horse, J.G. (1982). American Indian and Alaskan Native Elders: Policy Critique. In J.B. Cuellar, E.P. Stanford, D.I. Miller-Soule (eds.), Understanding Minority Aging: Perspectives and Sources, pp. 59-85.

This critique focuses on general population characteristics of American Indian elders and makes specific recommendations for direct funding strategies to American Indian and Alaskan Native tribes and villages. Urban elders are referenced as: 1) having been categorically excluded from the Bureau of Census methodology in 1970; 2) being in "quadruple jeopardy" since they age before reaching the appropriate chronological years; and 3) preferring to receive services from American Indians who do not inspire fear and institutional barriers to service delivery.

policy, service delivery

Red Horse, J.G., Ledingham, J., Decker, J.T. (1979). American Indian Elders: Perspectives on Cultural Behavior and Needs. Paper presented at the Annual Meeting of the Society for the Study of Social Problems. Boston, MA. Summer, 1979.

This paper presents findings of a study of elders residing in St. Paul, MN. Grandparent - grandchild contact was analyzed and results indicate that 70% of the grandparents had daily contact with their grandchild, although the majority (92%) lived in separate residences. Conclusions suggest that the Indian family is intact, the extended family system operates in the urban context, and that elders have significant family roles.

residential patterns, social roles

Red Horse, J.G., Shattuck, J., Hoffman, F. (1981). The American Indian Family: Strengths and Stress. Proceedings of the Conference on Research Issues, April 17-19, Phoenix, AZ. Isleta, NM: American Indian Social Research and Development.

These proceedings describe family roles in traditional and contemporary societies. Urban families usually are the target of a negative focus in research, whereas the extended family is actually a source of strength. Examples of urban elderly include re-examination of a situation of social disorder and material deprivation to understand the strengths of family and the social roles of an older American Indian woman on welfare, providing care for substance abusing youths.

social roles

Red Horse, J.G., Lewis, R., Feit, M., Decker, J. (1978). Family Behavior of Urban American Indians. Social Casework, pp. 67-72.

American Indian family network behavior is described in general and specific examples in Minneapolis are cited. The grandparent leadership role is both "official" and "symbolic," the latter being generalized to adoption of unrelated elders into the family. The consequence of family network behavior is closure of the American Indian community to non-Indian service agencies despite the continual recruitment efforts of those agencies.

service utilization, social networks, social roles

Red Horse, Y. (1982). A Cultural Network Model: Perspectives for Adolescent Services & Paraprofessional Training. In S.M. Manson (ed.), New Directions in Prevention Among American Indians and Alaskan Native Communities (pp. 173-185). Portland, OR: National Center for American Indians.

This paper introduces an innovative family-as-treatment model mental health program, WIDO-AKO-DA-DE-WIN. This program employs the natural support system provided by Indian elders in a preventive strategy for adolescents. The importance of family and family-like networks are built upon trust, realistic expectations, and non-judgmental behavior, as lived through the wisdom of the Indian elders.

model programs, social roles, sociocultural values

Rhoades, E.R., Marshall, M., Attneave, C., Echohawk, M.B. (1980). Impact of Mental Disorders upon American Indians as Reflected in Visits to Ambulatory Care Facilities. Journal of the American Geriatrics Society 28(1), 33-39.

Mental health statistics from the Portland and Albuquerque areas are presented, broken down by age. The 65+ population tends to use less services and has a higher rate of visits for "social" problems rather than for mental health disorders. The 45-54 age group contributes greater than expected visit prevalence for each mental health category. For those 65+, the only category with significantly greater than one was organic brain syndrome.

mental health

Richek, H.G., Chuculate, O., Klinert, D. (1971). Aging and Ethnicity in Health Elderly Women. Geriatrics, 146-152.

Using the Bown Self-Report Inventory, the disengagement and aging process was studied for 35 older American Indian women (mean age 71.7 years) and 15 Caucasian women (mean age 73.9 years) living in their own residences or in golden age homes in Oklahoma (no further information was given on location for this study). Significant differences were found between American Indian and non-Indian women in the disengagement process. American Indian women disengaged from peers,work, optimism and general satisfaction with their environment, while non-Indian women disengaged from children, parents, and authority figures. The authors speculate that the prevalence of the extended family maintenance throughout a lifespan, the continuation of tribal membership ties account for the lack of change in attitudes toward family and authority in American Indian women. They also suggest that American Indian religion may impact on the negative attitude on the "hope" scale. Recalling earlier, happier days, American Indian women report significantly more positive attitudes toward children and authority figures than do non-Indians. The latter group reported significantly more positive attitudes toward work during that time.

aged: defined, ethnicity

Santos, J.F., Hubbard, R.W., McIntosh, J.L. (1983). Mental Health and Minority Elderly. In L.D. Beslau and M.R. Haug (eds.), Depression and Aging: Causes, Care and Consequences (pp. 51-70). New York: Springer.

Although urban American Indians living in the Pacific Northwest, Portland, and Albuquerque suffer from depression, alcoholism, anxiety, and maladjustment, there are no specific findings relating to depression or personality characteristics among Indian elderly, regardless of location.

mental health

Shore, J.H., Kinzie, J.D., Hampson, J.L., Pattison, E.M. (1973). Psychiatric Epidemiology of an Indian Village. Psychiatry 36, 70-80.

One hundred of 200 adults in a Northwest coast lumbering on-reservation Indian community were assessed. Fifty-four percent rated having a definite psychiatric disturbance, while an additional 15% had probable psychiatric disturbance. There were lower probability and impairment ratings for older subjects in comparison to younger subjects of both sexes. Highest impairment was for men in their 30's; the highest for female morbidity was between 20-40 years. Lowest income groups were associated with the greatest problems. Physical illness showed no relation to psychiatric disturbance. Those born outside the village had higher ratings of impairments. Social factors, religious affiliation, and activities had no relation to disability. Alcoholism was the major psychiatric problem. Medicine and physician utilization patterns differ according to gender.

mental health

Smith, E.M. (1987). Health Care for Native Americans: Who Will Pay? Health Affairs, Spring, 123-128.

This overview of Indian Health Services (IHS) funding - or lack thereof - notes that little is known about urban American Indian health problems.

overview

Spencer, R.F., Jennings, J., et al. (1965). The Native Americans: Prehistory and Ethnology of the North American Indians. New York: Harper and Row.

Typically there are no enclaves of urban American Indians, the few exceptions are identified.

overview, residential patterns

Stuart, P., Rathbone-McCuan, E. (1988). Indian Elderly in the United States. In Rathbone-McCuan, E. and Havens, B. (eds.), North American Elders: United States and Canadian Perspectives.

This essay reviews Indian policy, key federal agencies mandated to serve Indians, and demographic data. Stuart and Rathbone-McCuan note gaps of information based on data collection on reservation where only 1/4 of Indian elderly reside. The significance of designation as a priority group is discussed and the authors recommend that Title VI be extended to urban areas with large Indian populations.

demographics, health, policy

Taylor, B.J., Peach, W.N. (1974). Social and Economic Characteristics of Elderly Indians in Phoenix, Arizona. Journal of Economics & Business 26(2), 151-155.

This study (N=144) examines the social and economic characteristics of elderly American Indians living in Phoenix, Arizona. It focuses on attachment to reservations,education and employment. Taylor and Peach discuss the return of the elderly to reservation life, as well as income sharing and other related economic considerations.

education, employment, ethnicity, migration, socioeconomics

Taylor, T. (1988). Health Problems & Use of Services at Two Urban American Indian Clinics. Public Health Reports 103(1), 88-95.

A survey of 1000 medical records was obtained from Urban Indian clinics in Oklahoma City, Oklahoma, and Wichita, Kansas and compared with demographic and health use data for all Indians and the general U.S. population. Findings indicate that urban Indian health clinic users typically were impoverished, had little education, and were unlikely to have health insurance. Although urban IHS clients utilize health care services less frequently that rural IHS clients, the general health problems and needs were comparable.

education, health, socioeconomics

U.S. Commission on Civil Rights (1982). Minority Elderly Services: New Programs, Old Problems. Washington, D.C.:U.S. Government Printing Office.

This report presents data on Title III service utilization by minorities in key cities. Barriers to access for American Indians include staffing patterns. Overall, minorities continue to underutilize services available.

barriers, policy, service utilization

U.S. Senate Special Committee on Aging, Subcommittee on Long-Term Care. 92nd Congress (1972). Trends in Long Term Care, Part 20 (Access of Minority Groups to Nursing Homes), Serial #62-264. Washington, D.C.: U.S. Government Printing Office.

This report on long-term care for American Indian elderly examines current life expectancy at 47 years and the placement in non-Indian nursing homes off-reservation. There are few urban, culturally sensitive long-term care institutions for the aged urban American Indian.

health, long term care, policy

U.S. Senate Special Committee on Aging. (1986). The Older Americans Act & Its Application to Native Americans, 99th Congress, 2nd Session, Series #99-22. Washington, D.C.: U.S. Government Printing Office.

This hearing focused on the need to provide improved support services under the Older Americans Act. Three panels judged the effectiveness of the Administration on Aging in addressing the special needs of American Indian elderly: i.e., AoA's sensitivity to American Indians, coordination of services provided by Titles III and VI, and the availability of services under the Act, as well as the need for clear guidelines.

barriers, nutrition, policy, service delivery, social services

U.S. Senate Special Committee on Aging. (1987). The Continuum of Health Care for Indian Elders. Serial #99-27. 99th Congress, 2nd Session. Washington, D.C.: U.S. Government Printing Office.

This completed a series of hearings on the quality of health care facing older Americans. State, federal, and tribal health services available to American Indian seniors were assessed with no specific discussion regarding urban American Indian elders.

health, policy, social services

U.S. Senate Special Committee on Aging. (1989). The American Indian Elderly: The Forgotten Population, Special Hearing Committee on Aging, 100th Congress, 2nd Session. Washington, D.C.: U.S. Government Printing Office. 171 pp.

This Senate hearing testimony focused on needs of elderly American Indians who receive services from Indian Health Services, the Bureau of Indian Affairs,and Titles V and VI of the Older Americans Act. Incidental mention of urban American Indian elderly is included in the testimony of Cecilia Montgomery on housing, and Dr. Spero Manson on mental health.

health, housing, mental health, policy

Weeks, J.R., Cuellar, J.B. (1981). The Role of Family Members in the Helping Networks of Older People. The Gerontologist 21(4), 388-394.

The results of the survey of older people in San Diego County are examined for helping networks. Urban and rural American Indians are apparently lumped together in analysis and comparison with other ethnic groups.

social roles

Weibel-Orlando, J. (1988). Indians, Ethnicity as a Resource and Aging: You Can Go Home Again. Journal of Cross-Cultural Gerontology 3, 328-348.

Return migration and the role of ethnicity in establishing group membership is examined within the context of the life history of a Sioux woman returning to her natal reservation after 26 years of living in Los Angeles, California.

life history, migration

Weibel-Orlando, J., Kramer, B.J., et al. (1989). Urban American Indian Elders Outreach Project, Final Report of AoA Demonstration Project, Grant 90 AMO273. Los Angeles, CA: County of Los Angeles, DCSCS.

Findings of the 328 in-depth needs assessments of elders (median age 58 years) in Los Angeles, California, are reported. Linkage in supportive services was conducted and evaluated. Recommendations for policy to the Area Agency on Aging, the local community, and other governmental agencies are made. The elders prioritized their needs for services and activities for an American Indian senior citizens' center.

assessment, health, model programs, service delivery, social services

Weibel-Orlando, J. (1989) Elders and Elderlies: Well Being in Indian Old-Age. American Indian Culture & Research Journal 13(3&4), 75-87. UCLA: American Indian Study Center.

Ethnic community involvement in both urban and rural American Indian communities contributes to the positive social and psychological well-being of being an elder. Isolation from the community, particularly among older urban American Indians, promotes sociocultural marginality and a negative self-concept as an "elderly."

aged: definition, social roles

Williams, B.S. (1978) Social, Economic and Health Characteristics of Older American Indians. DHEW Pub. No. (OHDS) 78-20289. DHEW, OHDS, AoA.

Based on the 1970 U.S. Census, there are few comparisons between urban and reservation/rural dwelling older Americans. Health data is based exclusively on Indian Health Service reports and these services are denied to urban dwelling American Indians. The majority of both rural and urban older American Indians live in poverty at a rate twice that of the total older population. This condition reflects low wages, low educational attainment, and limited working opportunities during younger working years, in comparison to other elderly. Income maintenance is further affected by marital status: 2/3 of all older American Indian women and 37% of all American Indian men are either single, widowed, or divorced.

social roles, socioeconomics

Williams, G.C. (1980). Warriors No More: A Study of the American Indian Elderly. In C.L. Fry (ed.), Aging in Culture and Society: Comparative Viewpoints and Strategies (pp.101-111). NY: Bergin & Garvey Publishers, Inc.

Aging among non-reservation American Indians living in Oklahoma is defined by functionality rather than by chronology. Unlike the general population, aged Indians are treated individually, not as a group, and the individual's status is related to his/her ability to functions in the past as well as the present. The effects of industrialization, higher rates of mobility, and technological change have exerted little influence on the Indian family in Oklahoma. An area of conflict in roles and values is the trend for younger, better educated tribal members to accept positions of leadership and authority.

aged: defined, social roles, sociocultural values

Selected References on Experiences of Contemporary Urban American Indian Elders

Ablon, J. (1965). American Indian Relocation: Problems of Dependency and Management in the City. Phylon 26, 362-371.

Ablon reports that the relocation program return rates were as high as 75% and stabilized at 35%. However, 75% of her respondents would return from the San Francisco area to their reservations if comparable jobs existed on the reservation.

policy, service delivery, service utilization

Bahr, H.M. (1972). An End to Invisibility (Introduction to Chapter 6, Urban Indians). Native Americans Today: Sociological Perspectives, pp. 401-404. New York: Harper and Row.

This introduction to a chapter on American Indian "invisibility" notes that at times Indians get "lost" statistically and psychologically; this frequently leads to the issue of Indian invisibility. However, this phenomenon is being replaced by a new Pan-Indianism as a result of Red Power movements that provide a power base for American Indian people.

mental health, sociocultural adaptation, sociocultural values

Bahr, H.M., Chadwick, B.A., Day, R.C. (eds.) (1972). Native Americans Today: Sociological Perspectives. New York, NY: Harper & Row Publishers, Inc.

This book is a collection about American Indians in which several chapters are devoted to the urban American Indian. (NOTE: Urban populations generally are younger than rural or reservation populations.) In particular, the contributors write about psychological variables, the problems associated with urbanization and relocation, as well as with identity issues related to moving away from reservations.

mental health, migration, sociocultural adaptation

Bramstedt, W.G. (1977). Corporate Adaptations of Urban Migrants: American Indian Voluntary Associations in Los Angeles. Unpublished Ph.D. thesis, UCLA. 481 pp.

This dissertation addresses critical gaps in urban American Indian literature. There is a lack of knowledge about American Indian patterns of relations and the institutions that socially organize urban American Indians in their new environment. Bramstedt's comprehensive study (1968-1971) of voluntary associations in the Metropolitan area of Los Angeles County is an attempt to narrow these gaps. Indian voluntary associations represent complex external relations of overlapping memberships.

migration, sociocultural adaptation

Castro, T. (1972). Crisis of the Urban Indian. Human Needs 1(2), 29-31.

Urban Indians prefer that government services be channeled to American Indian organizations. There is a strong hesitancy of urban Indians to participate in federal (or other) programs, fearing that there are "strings attached." Indians' lack of education concerning social services has created a gap in accessing services and in communication with these agencies.

social services

DeGeynt, W. (1973). Health Behavior and Health Needs of Urban Indians in Minneapolis. Health Services Report 88 (April), 360-366.

In a Minneapolis sample of 225 households agreeing to be surveyed (N=291), three households reported respondents received "old age" assistance. The study reports: 1) demographic and socioeconomic information; 2) mobility patterns; 3) utilization patterns; 4) identification of major social problems perceived by urban Indians; and 5) Indian attitudes about health clinics and the financing of health services. These findings support former President Richard M.. Nixon's assertion that American Indians are the most deprived and isolated minority in the United States. This study documents the preference for receiving services from American Indian staff. Efforts to meet health care needs must be coordinated with efforts to solve other social problems (e.g., housing, education, and employment).

health, service utilization

Dowling, J.H. (1968). A "Rural" Indian Community in an Urban Setting. Human Organization 27, 236-240.

Dowling compares the Oneida community, which is less than 10 miles from Green Bay, a rapidly expanding industrial and commercial city. The Oneida community is characterized by poverty. The demographic pattern of the Oneida community is high dependence and non-productivity, and high under- or unemployment for those 18-64; the median age of the Oneida community is 17, compared to Green Bay with a median age of 25. Despite the relative proximity of these two settings, the social distance is the equivalent of territorial distance.

demographics, employment, sociocultural values

Farris, C.E. (1976). American Indian Social Worker Advocates. Social Casework, 494-503.

Extensive research is cited as indicating that no advocacy programs have been attempted specifically directed at urban American Indians, except for limited precedents at urban Indian centers. The lack of social work and Bureau of Indian Affairs programs for urban Indians is decried from moral and professional points of view because is fosters greater social and economic burdens for society. Urban Indians are described as more susceptible to alcoholism, crime, poverty and suicide than reservation-dwelling Indians.

social roles, social services

Federal Council on the Aging (1979). Policy Issues Concerning the Elderly Minorities. DHHS Publication No. 80-20670. Washington, D.C.: U.S. Government Printing Office.

This overview of minority aging concerns includes a chapter on American Indians based on the 1970 Census, but does not include specific discussion or policy recommendations for urban American Indian elderly.

health, overview, policy,

Fiske, S. (1978). Rules of Address: Navajo Women in Los Angeles. Journal of Anthropological Research 34(1), 72-91.

Fiske examines the use of social terms by Navajo migrant women to Los Angeles, aged 29-33 years. In status-marked settings (e.g., interactions with bureaucracy, BIA), Navajo overcorrect for Anglo ethnicity and behave in a manner which appears to be "shy" or "unassertive". Informality is the appropriate interaction norm.

ethnicity, sociocultural values

Frost, R. (1973). A Study of a Los Angeles Urban Indian Free Clinic & Indian Mental Health Problems. Unpublished Master's Thesis, California State University, Long Beach.

In this master's thesis, Frost traces the founding of the Indian Free Clinic in Los Angeles County and its subsequent split into two clinics. He examines how this split affected the efficiency and ability to offer services.

health, mental health, service delivery

Fuchs, M. (1974). Health Care Patterns of Urbanized Native Americans. Unpublished Ph.D. Thesis. University of Michigan, Ann Arbor, Michigan.

To provide a better understanding of health care problems and behaviors of urban American Indians living in the San Francisco Bay Area, this dissertation examined relationships between the political environment and problems encountered in the utilization of health services. Fuchs analyzed employment, income, and third party coverage to determine their potential impact on service utilization and health behavior. Fuchs discovered that the later political economic variables had much greater influence on health behavior than did acculturation variables, such as native language ability, tribal affiliation, and use of traditional medicine.

employment, health, service utilization, sociocultural values, socioeconomics

Graves, T.D., Van Arsdale, M. (1966). Values, Expectations and Relocation: The Navajo Migrant in Denver. Human Organization 25(4), 300-307.

Tenure in cities is described as tenuous and dependent only on economic conditions.

migration, sociocultural values

Graves, T.D. (1966). Alternative Models for the Study of Urban Migration. Human Organization 25(4), 295-301.

Research on Navajo migration to Denver uses three convergent models: decision-making, assimilation, and economic adjustment. These latter models also account for personality variables, beliefs, social group identification, and economic training and experience that explain why Navajo stay or leave Denver.

migration

Hanson, M.R. (1960). Plains Indians and Urbanization. Unpublished Ph.D. Thesis. Stanford University. 176 pp.

This dissertation consists of more than 80 interviews with Plains Indians who migrated to metropolitan areas and with Crow and Northern Cheyenne Indians who had returned to the reservation. Hanson asked those interviewed to recount pre-location, location, and post-location experience. Gender differences were noted with a greater inability of women to adjust to urban life.

migration, sociocultural adaptation

Jeffries, W.R. (1972). Our Aged Indians. In National Council on Aging, Triple Jeopardy: Myth or Reality, 7-10. Washington, D.C.: NCOA.

As one of four papers included in the 1971 Regional National Council on Aging Meetings, the paper by Jeffries, Special Assistant for Indian Affairs to Governor Daniel J. Evans (Washington), laments the way American Indians, the "forgotten" people, have been neglected in terms of services and benefits. He claims that American Indians have been stereotyped as alcoholic, non-competitive, naturally poor students, who are passive-aggressive. Jeffries, himself of American

Indian heritage, urges enabling Indians to help themselves by working with them rather than, and possibly inadvertently, against them.

health, sociocultural adaptation, sociocultural values

Johnston, F.E., McKigney, J.I., Hopwood, S., Smelker, J. (1978). Physical Growth and Development of Urban Native Americans: A Study of Urbanization and its Implications for Nutritional Status. American Journal of Clinical Nutrition.

This article examines growth measurements of Indians in Minneapolis from age 22 days to 19 years. Undesirable aspects of urban as opposed to a traditional reservation environment are noted.

health, migration

Jones, D.M. (1974). The Urban Native Encounters the Social Service System. Institute of Social, Economic and Government Research. Fairbanks: University of Alaska.

One-third of clients in Jones' sample found experience with social service agencies beneficial; these were usually short-term needs for a single service. Another third could not categorize outcome. The remaining third perceived their experience as destructive, humiliating, and/or an invasion of privacy and of cultural values. Social service agencies promote deviations: suicides, alcoholism, and rootlessness. Recommendations are to transfer services to native regional organizations, to allocate resource distribution to native agencies so they cannot be undermined by competitor agencies; through these recommendations, leadership experience roles for native youth will emerge.

ethnicity, social services

Jones, D.M. (1976). Urban Native Men and Women - Differences in Their Work Adaptations. Institute of Social, Economic and Government Research. Fairbanks: University of Alaska.

Contrary to the androcentric literature on American Indian and Alaskan Native adaptation to urban environments, Jones finds that Alaskan Native women adapt more successfully than men do in cities. Women are more able to find steady low skill jobs and less competition and discrimination than men. Women are able to fulfill primary socialization roles as wife/mother and are passive and subservient in relationships with authority. In her sample of 101 persons, one was aged 60+, nine were 50-59 years.

ethnicity, social roles, social services, sociocultural adaptation

Kerri, J.N. (1976). "Push" - "Pull" Factors: Reasons for Migration as a Factor in American Urban Indian Adjustment. Human Organization 35, 215-220.

Kerri introduces the notion of push and pull factors affecting the adjustment of American Indians to urban life. He notes that economic opportunity is a major factor in decisions to migrate to urban areas.

demographics, migration, sociocultural adaptation, socioeconomics

Levitan, S.A., Johnston, W.B. (1975). Indian Giving: Federal Programs for Native Americans. Baltimore: John Hopkins University Press.

The problem of Indians is a reservation problem. "Off the reservation, Indians are better off than other American minorities, though they still suffer by comparison to whites." (pp. 72-73.) Ultimately, the federal government should leave the resolution of the Indian problem to Indians.

policy

Levy, J.E. (1967). The Older American Indian. In E.G. Youmans (ed.), Older Rural Americans: A Sociological Perspective, pp. 221-228. Lexington, KY: University of Kentucky.

Conditions of aging Indians are represented for the Navajo in Utah, Arizona, and New Mexico. The young who migrate seasonally to cities and the rural old are developing a generation gap. The Indian expectation of America is inseparable from treaty rights and its relation to the federal government.

ethnicity, policy, social roles

Lewis, R.G. (1975). Social Work with Native Americans. Social Work 20(5), 379-382.

Lewis notes generalizations about American Indian customs and values that impact on the often intrusive non-Indian job of social work. Lewis also suggests why Indians need to have exclusive groupings because of vast cultural differences (presumably in group behaviors).

social services

Locklear, H.H. (1972). American Indian Myths. Social Work 17(3), 72-80.

Locklear outlines guidelines on how Indians relate to each other and to non-Indians.

sociocultural values

Los Angeles City/County Native American Indian Commission (1986). Utmost Good Faith? American Indians in Los Angeles County's Urban Reservation.

General problems for the entire Indian population were aired in a public hearing with no specific mention of the problems of the elderly. Two issues, however, bear on the elderly: disruption of traditional indigenous burial grounds (archaeological) for urban development and regulations that inhibit practice of traditional religion.

sociocultural values

Manson, S.M. (1989). Provider Assumptions about Long-Term Care in American Indian Communities. The Gerontologist 29(3), 355-358.

A survey of 208 Indian Health Service (IHS) providers and tribal community health representatives (CHR) indicates that long-term care is conceived as exclusively limited to rehabilitation and protection. Supportive services are not conceived as part of long-term care. Recommendations are made to educate tribal and IHS gatekeepers.

service delivery, social services

Manson, S.M., Shore, J.H., Bloom, J.D. (1985). The Depressive Experience in American Communities: A Challenge for Psychiatric Theory and Diagnosis. In A. Kleinman and B. Good (eds.), Culture & Depression (pp. 331-368). Berkeley: University of California.

Manson et al. ask how depression is conceptualized and experienced by American Indians and to what extent it is similar to other cultural and ethnic groups. The sample of 54 Hopi (aged 17-54) was divided into 3 age groups (17-30, 31-50, 51+), which includes twenty subjects from the patient population of a local urban American Indian mental health program. There was a high prevalence of depression, a disease which can easily be misdiagnosed. They urge the consideration of culture for effective planning and delivery of cross-cultural mental health services.

health, mental health, service delivery, sociocultural adaptation

Manuel, R.C., Berk, M.L. (1983). A Look at Similarities and Differences in Older Minority Populations. Aging 339, 21-29.

This article presents a comparison of older blacks, older whites and all other minority groups (lumped together because of limited data). Native Americans are indicated on national samples which do not indicate provenance of data collection. Some indicators may lump urban and rural older minority members. Conclusion: minority aging is too heterogeneous to lump.

McKinley, J. (1983-1984). Suicide Among Native Americans: Further Tribal Data and Considerations, Omega 14, (3).

Unlike the general population, older American Indians are less likely to attempt suicide than any other group of older Americans. Various reasons for this are cited. In addition, suicide trends are considered for tribal reservation communities.

overview

Miller, N.B. (1982) Social Work Services to Urban Indians. In J.W. Green (ed.), Cultural Awareness in the Human Services (pp. 157-183). Englewood Cliffs, N.J.: Prentice Hall.

Based on an outreach project in Los Angeles County to 400 families (2,000 individuals), an interdisciplinary approach is promoted which blends anthropological theory with social work knowledge and practice. Health and social services described relate to developmental disabilities. Institutional barriers include financial problems, lack of understanding about agency procedures, transportation, lack of child care services, waiting time, and impersonal interactions.

barriers, health, rehabilitation, social services

Neils, E.M. (1971). Reservation to City. Chicago: University of Chicago.

Urban migration of American Indians is presented from a geographic approach using various data sources, but does not focus on older American Indians. Casual mention is made of elders in regard to demographic patterns of settlement in large metropolitan areas.

demographics, education, migration, residential patterns

Pambrun, A.M. (1980). Mental Health and Ethnic Minorities. In Manpower Considerations in Providing Mental Health Services to Ethnic Minority Groups (pp. 64-72). Boulder, Colorado: Western Interstate Commission on Higher Education.

This chapter defines barriers to accessing health and mental health services by urban American Indians, yet there is no reference to age. Greater cultural toleration of mental illness and mental retardation results in family and community care rather than in institutionalization. Cultural misunderstandings by Anglo service providers label those who seek assistance as uncooperative.

barriers

Powelson, M.K. (1984). Alcatraz Revisited. San Francisco Focus, pp. 32-38, 80.

In describing the takeover of Alcatraz Island by American Indians, political legitimacy is conferred by the blessing given by a 65 year old Chamach medicine man and by the comments offered by an elder Klamath woman who did not participate in any political events but felt proud by the actions taken on Alcatraz.

policy, social roles

Price, J. (1968). The Migration and Adaptation of American Indians in Los Angeles. Human Organization 27, 168-175.

Individuals of 100 different tribes adapted to Los Angeles and adaptation is facilitated by intertribal organizations.

migration, sociocultural adaptation

Secombe, K. (1989). Ethnicity or Socioeconomic Status? Health Differences between Elder Alaskan Natives and Whites. The Gerontologist 29(4), 551-556.

Alaskan Natives, the majority of whom live in rural areas, report poorer health self-ratings than whites; however, this difference disappears when socioeconomic factors of income, education, gender, and age are controlled through a multivariate analysis.

ethnicity, health, socioeconomics

Shannon, G.W., Bashsshur, R.L. (1982). Accessibility to Medical Care Among Urban American Indians in a Large Metropolitan Area. Social Science Medicine 16, 571-575.

In this study of urban Indians in Wayne County, Michigan, the percentage of elderly is not specified. Differential access in health care was found between residential areas. Measures of accessibility includes travel time, appointment delay time, and waiting room time.

health, service utilization

Sorkin, A. (1969). Some Aspects of American Indian Migration. Social Forces 48(2), 243-250. This article briefly describes the direct employment program and the adult vocational training programs and their impacts. Between 1952-1968, over 100,000 Indians participated in these programs to relocate American Indians to urban areas. The most successful migrants are younger, have more education, and are of mixed blood. At least three of ten relocatees return to their reservation within the first year of entry into these programs. The scale of these two programs is not sufficiently great to alleviate the excess of the unemployment population on reservations.

migration

Sorkin, A. (1978). The Urban American Indian. Lexington, MA: D.C. Health & Co.

This thorough treatment of urban American Indian life does not focus on older American Indians. However, casual mention is given to the educational attainment, use of social services, assimilation, and return migration by older American Indians in the 1970's.

education, migration, social services, sociocultural adaptation

Strong, C. (1984). Stress & Caring for Elderly Relatives: Interpretations & Coping Strategies in an American Indian and White Sample. The Gerontologist 24(3), 251-255.

A sample of 10 Indian and 10 non-Indian caregivers were matched for sex, income, and education in a rural west Washington state area. The greatest difference between Indian and non-Indian caregivers was in the area of control. Passive forbearance for American Indians is a stress reduction strategy that mitigates feelings of frustration, anger, and ultimately guilt.

health, mental health

U.S. American Indian Policy Review Committee (1976). Report on Urban and Rural Non-Reservation Indian. U.S. Task Force 8 Committee Print. Superintendent Documents #Y4IN-2/10:UR. Washington, D.C.:U.S. Government Printing Office. 144 pgs.

This final committee report concludes that since the 1928 urban hearings, the prevailing policy has been to provide services only to reservation American Indians, while also encouraging relocation from the reservation to the city, where, for the most part, American Indians have been unable to establish themselves.

migration, policy, service delivery

U.S. House of Representatives Select Committee on Aging. (1989). Hispanic and Indian Elderly: America's Failure to Care. Washington, D.C.: U.S. Government Printing Office.

Testimony by the National Indian Council on Aging on the condition of American Indian elderly reviews the demography, physiology, psychology, sociology of American Indian aging with little documentation. Policy is recommended. No specific mention of urban American Indian elders.

policy, social services

U.S. Senate Select Committee on Indian Affairs. (1982). Federal Aging Programs Oversight Hearings. Washington, D.C.: U.S. Government Printing Office.

These hearings highlight the lack of coordination between agencies having responsibility for elderly American Indians. In his testimony, Larry Curley of NICOA advises the committee that

the OARS data collected by NICOA on urban elderly is from too limited a sample to generalize the findings.

demographics, policy

U.S. Senate Special Committee on Aging. (1971). Advisory Council on the Elderly American Indian: A Working Paper. Washington, D.C.: U.S. Government Printing Office.

Although off-reservation elderly are acknowledged, the focus of this working paper is on reservation elderly. Policy recommendations for the Indian elderly include no-cost housing, guaranteed annual income, senior centers, and nutrition programs.

policy, service delivery

Waddell, J.O., Watson, O.M. (eds.) (1971). The American Indian in Urban Society. Little Brown Series in Anthropology. Boston: Little, Brown & Company.

This book laments the dearth of accessible resource materials about urban Indians, which are currently only available from unpublished theses. Three major points are raised: the importance of structural factors (institutional strategies other than acculturation to study American Indians in urban America); whether we should concentrate on the social problems of urban Indians, or rather, their successes; and, the impact of educational background, employment opportunities, and psychological stability on the ability of urban American Indians to make the transition from reservation to city.

overview

Wax, M. (1971). Indian Americans: Unity and Diversity. Englewood Cliffs, NJ: Prentice Hall.

There is a chapter in this monograph on urban Indians which describes the heterogeneity of socioeconomic stratification of American Indians from different tribes and in different cities.

social roles, sociocultural values

Weibel-Orlando, J. (1990). Grandparenting Styles: American Indian Perspectives. In J. Sokolovsky (ed.), The Cultural Context of Aging, pp. 109-126. New York, NY: Bergin & Garvey.

The social roles of 26 elders who had lived in urban areas or off-reservation but who had returned to their natal reservations are described in terms of cultural conservator, custodian, ceremonial, distanced, and fictive functions.

social roles

Westermeyer, J., Peake, E. (1983). A Ten-Year Follow-up of Alcoholic Native Americans in Minnesota. American Journal of Psychiatry 140(2), 189-194.

This article examines a ten year follow-up of 45 alcoholic American Indians, of whom 93%, or 42, were located. Westermeyer and Peake suggest that in the absence of steady employment and a stable marriage or relationship and family environment, the effectiveness of treatment efforts was reduced. They also noted the importance of Indian treatment programs. The subjects aged 65+ were among the 16% who showed improvement.

employment, health, model programs, rehabilitation, social services

White, L.C., Chadwick, B.A. (1972). Urban Residence, Assimilation & Identity of the Spokane Indian. In Bahr, H.M. et al., Native Americans Today (pp. 239-249). New York, NY: Harper & Row Publishers

This chapter addresses the progressive nature of the American Indian's urban relocation and the stage-like process of assimilation. White and Chadwick found that Indian-white interaction was a more critical factor of "success" than education and employment, as had previously been assumed.

mental health, sociocultural adaptation, sociocultural values

Williams, B.S. (1978). Social, Economic and Health Characteristics of Older American Indians. DHEW Publication No. (OHDS) 78-20289.

Health conditions of urban Indians could not be reported because no Indian Health Services (IHS) statistics are available. Other government data indicates that poverty and the high percentage of single, divorced, and widowed older adults have important implications for maintenance of income and family responsibilities. Most of the data reviewed refers to reservation dwelling older American Indians.

social roles, socioeconomics

Bibliographies on Aging of American Indians

Bramstedt, W.G. (1979). Public Administration Series P233, pp. 14. Monticello, IL: Vance Bibliographies.

This brief (14 pages) bibliography lists over 125 sources. A referece list at the end provides additional resources of issues to pursue related to American Indians.

bibliography

Bramstedt, W.G. (1979). North American Indians in Towns & Cities: A Bibliography. Public Administration Series P234. Monticello, IL: Vance Bibliographies.

This bibliography contains approximately 850 sources. The introduction notes that there is limited documented urban American Indian materials. This bibliography includes some sources that do not directly refer to urban American Indians but are related in subject or theme.

bibliography

Cuellar, J.B., Stanford, E.P., Miller-Soule, D.I. (1982). Understanding Minority Aging: Perspectives and Sources. University Center on Aging, San Diego: UCSC.

This bibliography on American Indian and Alaskan Natives lists 64 titles, including published and unpublished reports. While not distinguishing between urban and rural/reservation communities, the authors note that no references were available on nutrition, income/economics, transportation/mobility, nor leisure/recreation as distinct topic areas. References concern policy/legislation/legal (40.7%), literature review (18.5%), health (15.9%) mental health (10.6%), social network/family relations (9.7%), employment/retirement (2.6%), housing/living arrangements (1.7%), and education (0.8%).

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Phoenix, J., Miranda, K. (1980). The Elder American Indian. San Diego: Campanile Press, SDSU.

This monograph on elder American Indians also contains an extensive bibliography (pp. 35-36).

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This critical bibliography comes from the Newberry Library Center for the History of the American Indian, Chicago, Illinois. The introductory section gives a brief history of the relocation of American Indians, from reservations to cities. Although this bibliography is devoted to urban American Indians, there is slim to no mention of the aged urban American Indian; nevertheless, this collection is fairly comprehensive and covers literature that deals with the demographics, social and cultural aspects of urbanization, as well as with the nature of varying definitions of what it means to be "urban."

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